

Jorge Romero (Estate of Onystei Castillo-Lopez)

vs.

Berto Lopez, M.D.

Deposition of:

BERTO LOPEZ

January 10, 2019

PHIPPS REPORTING

Raising The Bar...

1 IN THE CIRCUIT COURT OF THE FIFTEENTH JUDICIAL
2 CIRCUIT IN AND FOR PALM BEACH COUNTY, FLORIDA

3 CASE NO.: 2018CA011332XXXXMB

4 JORGE DOUGLAS MIRANDA ROMERO, as Personal
5 Representative of the ESTATE OF ONYSTEI
6 CASTILLO-LOPEZ, Individually, and as Surviving
7 Spouse and Natural Parent and Guardian of CECILIA
8 MIRANDA CASTILLO, and JORGE JASON MIRANDA, minor
9 children,

10 Plaintiffs,

11 vs.

12 BERTO LOPEZ, M.D., BERTO LOPEZ, M.D., P.A., ALFRED
13 TOMASELLI, III, D.O., ALFRED TOMASELLI, III, D.O.,
14 P.A., REYNOLD DUCLAS, M.D., COLIN G. BROWN, M.D.,
15 COLIN G. BROWN, M.D., P.A., SHERIDAN HELATHCORP,
16 INC., TANVIR U. SALAM, M.D., and NUVIEW HEALTH,
17 LLC,,

18 Defendants.

19 _____ /

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21

22 VIDEOTAPE DEPOSITION OF

23

24 BERTO LOPEZ, M.D.

25

26

27

28 Thursday, January 10, 2019

29 10:51 a.m. - 3:14 p.m.

30

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32 Grossman, Roth, Yaffa, Cohen, P.A.

33 925 South Federal Highway

34

35 Boca Raton, Florida

36

37

38 Stenographically Reported By:
39 Richard Applebaum, RMR, FPR, CLR
40 Realtime Systems Administrator

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1 APPEARANCES:

2

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18 On behalf of Nuview Health, LLC:

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24 ALSO PRESENT: Steve Manno, Videographer;
John Pacenti; Alfred Tomaselli, III, D.O.

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I N D E X

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5 Examination

Page

6

Direct

By Mr. Cohen

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Cross

By Mr. Barker

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Cross

By Mr. Midwall

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Redirect

By Mr. Cohen

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Certificate of Oath

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Certificate of Reporter

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10

Read and Sign Letter to Witness

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Errata Sheet (forwarded upon execution)

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1 Thereupon,
2 the following proceedings began at 10:51 a.m.:

3 THE VIDEOGRAPHER: We're now on the
4 record. The time is 10:51 a.m. Today's
5 Thursday the 10th day of January, 2019. We're
6 here at 925 South Federal Highway, Suite 350,
7 Boca Raton, Florida, for the purpose of taking
8 the videotape deposition of Berto Lopez, M.D,
9 in the matter of Jorge Douglas Miranda Romero,
10 et al., versus Berto Lopez, M.D. et al.

11 The court reporter is Richard Applebaum.
12 The videographer is Steve Manno.

13 Will counsel please announce their
14 appearances for the record.

15 MR. COHEN: Yes. Thank you.

16 My name is Gary Cohen, and I'm here
17 representing Jorge Douglas Miranda Romero and
18 his two children Cecilia and Jorge Jr. and the
19 Estate of Onystei Castillo-Lopez.

20 MR. BARKER: Alex Barker here on behalf of
21 Dr. Alfred Tomaselli.

22 MR. CHIMPOULIS: Thank you.

23 Jay Chimpoulis for Dr. Duclas, Dr. Brown,
24 and Sheridan Healthcorp.

25

1 MS. PINEROS: Daniella Pineros on behalf
2 of Nuview Health and Dr. Salam.

3 THE COURT REPORTER: Doctor, raise your
4 right hand for me, please.

5 Do you swear that the testimony you are
6 about to give will be the truth, the whole
7 truth, and nothing but the truth?

8 THE WITNESS: I do.

9 Thereupon:

10 BERTO LOPEZ, M.D.
11 having been first duly sworn, was examined and
12 testified as follows:

13 DIRECT EXAMINATION

14 BY MR. COHEN:

15 Q. Good morning, Doctor.

16 A. Good morning.

17 Q. Give us your name, please.

18 A. Berto Lopez.

19 Q. And give us your current address.

20 A. Professionally, 1501 Presidential Lane,
21 Suite 21, West Palm Beach, Florida 33401.

22 Q. Okay. And your home address, sir?

23 A. 1746 Flagler Manor Circle, West Palm
24 Beach, Florida 33411.

25 Q. Okay. And you are a physician?

1 A. I am a physician specializing in
2 obstetrics and gynecology. Yes.

3 Q. Okay. As you know, you've been named as a
4 defendant in this case. And I represent the
5 Plaintiffs, who I've mentioned a minute ago. And
6 I'm going to be asking you a number of questions
7 today regarding background questions as well as
8 training and experience and then leading up to the
9 incident that happened in this case that eventually
10 led to the death of Onystei Castillo-Lopez.

11 At any time during my questioning if I'm
12 not making myself clear to you, if you don't -- if
13 you think you don't understand my question, you'd
14 like me to rephrase or reask the question, just say
15 so.

16 A. Okay.

17 Q. And, for the record, you are representing
18 yourself here by choice?

19 A. At this point; correct.

20 Q. At this point.

21 And I know you've had depositions before
22 and you've been an expert witness even, I believe,
23 before, so you understand the basics of how a
24 deposition works.

25 A. Yes, I do.

1 Q. Again, because you have no counsel here,
2 if at any point there's something that you need an
3 explanation on, please let us know and we'll try to
4 do the best we can.

5 A. Thank you for that.

6 Q. Are you currently in the active practice
7 of obstetrics and gynecology?

8 A. I am.

9 Q. And do you work for yourself or is there a
10 group that you work for?

11 A. I'm employed by my P.A., which is an
12 S corp, so I'm, basically, self-employed.

13 Q. And is it Berto Lopez, M.D., P.A.?

14 A. Correct.

15 Q. Okay. Is there any fictitious name that
16 hangs on your door that, you know, that you use?

17 Meaning, some people call it Florida
18 Obstetricians or whatever.

19 Do you have any name like that?

20 A. No.

21 Q. Okay. Hospital privileges-wise, do you
22 have hospital privileges presently?

23 A. No. I elected not to renew my hospital
24 privileges at Good Samaritan Medical Center. And
25 that was the only hospital I had active privileges

1 in at the time of this incident.

2 Q. Okay. St. Mary's prior to that --

3 A. Okay.

4 Q. They're both Tenet hospitals.

5 A. Yes.

6 Q. St. Mary's had taken away your privileges
7 prior to the birth of Jorge Lopez -- Jorge Miranda?

8 A. I believe that's a mischaracterization.

9 Q. Why don't we do it this way, why don't you
10 tell me what happened to your privileges at Good
11 Sam?

12 A. Okay. Good Sam or St. Mary's?

13 Q. St. Mary's first.

14 A. At St. Mary's.

15 During the course of a maternal death, an
16 investigation was begun and I was placed on
17 precautionary suspension. And I chose to withdraw
18 my privileges rather than go through their so-called
19 fair hearing process, because members that are now
20 part of the defendant class in that lawsuit included
21 the former chief of staff Dr. Borrego, who was a
22 trauma surgeon involved with the care and
23 coordination of the treatment of this particular
24 patient. The partner of Doctor -- I believe her
25 name was Shaw -- was also a party to and part -- and

1 a defendant in the lawsuit that subsequently
2 happened, as were either the -- certain members of
3 what could have been impaneled as part of the
4 hearing group. And there would have not been able
5 to have gotten a fair hearing inside of the hospital
6 policy process. So I made the decision to resign
7 while under precautionary suspension.

8 **Q. Okay.**

9 A. Rather than -- and allow the legal system
10 to decide in a much more impartial way as to whether
11 or not the care and treatment I delivered met the
12 standard of care.

13 **Q. All right. Did you feel that the way the**
14 **hearing was constituted that there was going to be a**
15 **bias against you?**

16 A. Without a doubt.

17 In fact, I had heard -- I'd been on staff
18 for maybe -- more than 25 years. I had heard
19 through the grapevine that some of the physician
20 groups who politically I had clashed with in terms
21 of privileging and credentialing some of their own
22 members thought that this was an opportunity to get
23 revenge, including one physician where I was -- I
24 signed the intent to initiate litigation against,
25 who was part of a committee that was very vocal

1 against me.

2 So I didn't think -- I thought with a jury
3 stacked against me before we even got started, it
4 made no sense.

5 And my legal counsel was the former
6 hospital attorney for St. Mary's for over 30 years,
7 and he knew some of the players, and agreed that the
8 wiser thing to do would be to resign while under
9 investigation. And that's what I chose to do.

10 **Q. Okay. So did the Department of Medicine**
11 **investigate that case?**

12 A. They did.

13 **Q. Is that the case that -- where a woman**
14 **bled to death?**

15 A. I'm not sure -- I think it was a little
16 more complicated than that.

17 **Q. The final result --**

18 A. The name of the case is Ashley Perez and
19 the -- and her representatives.

20 **Q. And I have the Department of Medicine**
21 **complaints in that regard.**

22 A. Right. Right.

23 **Q. I made it simple, in that without going**
24 **through all the details, the obstetrical woman,**
25 **patient of yours, wound up passing away; is that**

1 **correct?**

2 A. At the end -- because of delays that
3 were -- that occurred on the part of -- well,
4 actually, because of the denial of the on-call
5 surgeon as Wellington Regional Medical Center,
6 because of the delay in timely transferring her
7 because of an issue with the ambulance service, as
8 well as the patient's stability caused by the delay
9 in active transport, because of the failure of the
10 on-call trauma surgeon, who by contract served as
11 the intensivist, to timely see and evaluate this
12 patient over the course of several hours, despite
13 having been proven to have been in the unit itself
14 evaluating other patients, yes, at the end the
15 patient ultimately demised.

16 Q. And was the ultimate demise due to a
17 massive bleed that wasn't repaired or wasn't taken
18 care of?

19 A. The ultimate cause of death was bleeding,
20 yes.

21 Q. Okay. And is that the case, sir, that
22 the -- where the Department of Medicine filed a
23 complaint against you where you consented to a
24 judgment, not money judgment, consented to certain
25 restrictions on your license?

1 A. Well --

2 **Q. Your practice, I should say?**

3 A. In the form of the consent, the consent
4 agreement, I believe it's in the third paragraph,
5 indicates that I neither agree nor deny any of the
6 allegations.

7 The consent was an arbitration, where in
8 order to -- it's kind of like a plea agreement, that
9 I agreed that I would undergo certain conditions in
10 order to avoid a trial. At which point the trial
11 results would be uncertain, quite possibly --

12 **Q. I'm talking the Department of Medicine,**
13 **not a jury trial.**

14 A. It's an administrative judge trial in the
15 State of Florida.

16 **Q. Right.**
17 **Go ahead.**

18 A. Whereby I would bring my experts, they
19 could bring -- the department could bring their
20 experts.

21 Rather than going through the cost and the
22 uncertainty of an outcome of a trial --

23 And I might add, I have an expert opinion
24 by a very well respected OB/GYN in an independent
25 case regarding this very case that supports that

1 nothing I did was wrong.

2 I made the choice to enter into a plea
3 agreement in order to resolve the case.

4 Q. Okay. And so the board had charged you
5 with what they felt was negligent handling of the
6 case, but rather than go to a full hearing on it,
7 final determination, you agreed to in effect settle
8 it?

9 A. Well, it's a little more than that.

10 We had filed a response to their
11 complaint, and in the response to that complaint we
12 had provided defenses.

13 And rather than proceed with the cost and
14 the uncertainty of an outcome of an administrative
15 judge evaluation of the case, we chose to -- I chose
16 to accept their terms, while not agreeing or
17 admitting to liability or denying liability.

18 As I said --

19 I see you're looking at a copy of it.

20 You can read it into the record if you'd
21 like.

22 Q. We will read parts of it in.

23 But it actually doesn't say one way or the
24 other whether you were negligent or not, it doesn't
25 mention those words; in other words, the fact that

1 you neither deny or agree to the allegations against
2 you, it's not mentioned in the final order.

3 A. May I take a peek at that, sir?

4 Q. Sure.

5 A. Because I believe this is what it says
6 exactly.

7 Part Three, and this is on page 2 --

8 Q. Right. I'm here.

9 A. "For the purposes of these proceedings
10 Respondent neither admits nor denies the allegations
11 of fact contained in the administrative complaint."

12 Q. Okay.

13 A. And that's exactly what --

14 You know, I was trying to say it in like
15 regular talk rather than lawyer talk.

16 Q. I understand.

17 A. So the board accepted that I neither
18 admitted nor denied, as part of the agreement. And
19 it's a settlement before a trial.

20 Q. Well, let me read the next sentence. It
21 says, "Stipulated Conclusions of Law," in other
22 words that's what your counsel and you stipulated to
23 with the state "Respondent admits" -- that would be
24 you -- "admits that in his or her capacity"
25 licensed -- "as a licensed physician he or she is

1 the subject to the provisions of Chapter 456, 458
2 Florida Statutes, and the jurisdiction of the
3 department and the board," of course; correct?

4 A. Yes.

5 Q. Number two, "Respondent admits the"
6 facts -- "that the facts alleged in the
7 administrative complaint if proven would constitute
8 violations of Chapter 458 Florida Statute."

9 In other words, you're saying if the facts
10 that they laid out were proven, they would
11 constitute violations of standard of care by the
12 board?

13 A. Correct. If they were proven.

14 Now, if they were not proven, then the
15 board's actions would be dismissed. As I've seen
16 happen in other cases where I have been accused or
17 alleged --

18 Q. We'll get to those.

19 A. -- of negligence care.

20 So you're presumed innocent until proven
21 guilty.

22 So the presumption -- the language that's
23 contained in here merely says that if proven these
24 allegations.

25 But those allegations were neither proven

1 by a judge or not proven by a judge, as would happen
2 in an administrative complaint.

3 Q. Okay. Now, as a result of that complaint
4 and that order, which was entered in April -- excuse
5 me -- in May of 2017, which was just a few months
6 before Miss Castillo-Lopez was under your care at
7 Good Sam, there were certain things that you agreed
8 to as far as, number one, a reprimand; correct?

9 A. Yes. I accepted a letter of reprimand in
10 my file.

11 Q. And you also agreed to do a certain number
12 of continuing medical education in certain parts of
13 medicine such as risk management, and that would be
14 overseen by the board that you did them?

15 A. That's correct.

16 And I have completed all of them.

17 Q. Okay. And also in that order your
18 surgical privileges under the Board of Medicine in
19 the State of Florida were restricted in some regard;
20 correct?

21 A. Yes. The obligation imposed was that I
22 needed to have a Board certified OB/GYN present
23 during surgical procedures.

24 Q. Okay. And so that -- surgical procedures
25 include in your world of obstetrics and gynecology

1 would include what type of procedures?

2 A. I believe that a representation of what
3 would constitute an operation was initially
4 interpreted legally as a procedure performed in an
5 operating room.

6 Q. Okay. Now, in any labor and delivery of a
7 child you're aware, of course, that at some point
8 during that labor and delivery there may be for
9 various reasons a need for an emergency surgery?

10 A. Correct.

11 Q. And therefore -- and that could happen on
12 a minute's notice, basically. Something happens,
13 you quick have to make that decision.

14 And if you were in that position with that
15 restriction on you, would you have to have already
16 contacted an obstetrician to be available just in
17 case or would you have them in the room or how did
18 you handle that?

19 A. Okay. By agreement with the hospital and
20 the doctors that made up the committee that is the
21 medical executive committee, they were -- they
22 accepted that in the event that a surgical procedure
23 was going to be performed, that I had to have the
24 Board certified doctor at the time of the
25 performance of the surgery. There was not a time

1 limit. There was not a restriction as to at what
2 point of the surgery the surgeon would have to be
3 present.

4 In general, while on TV where commercials
5 come every 15 minutes, maybe every 12 minutes, the
6 action appears to be fairly rapidly. In the real
7 world of a medicine if a snap decision that an
8 intervention has to happen, it actually takes time
9 for the nurses to prepare an operating room, it
10 takes time for anesthesia to present themselves, it
11 takes time to get the equipment, the instruments,
12 the tools that the doctors are going to use. And in
13 general, in the old days they would say you have a
14 30 minute window obstetrically speaking from the
15 time of decision to the time -- the time of decision
16 to the time of incision, while that standard
17 generally doesn't apply.

18 **Q. Right.**

19 A. So if there was an incident where I felt
20 surgery, even emergent surgery was indicated, and
21 there are several areas in OB where that happens,
22 and GYN, I was able to have a physician,
23 Dr. Tomaselli, who agreed to cover me for that.

24 **Q. What if Dr. Tomaselli was involved in his**
25 **own surgery at the time, hypothetically?**

1 A. Correct. Then there was an emergency room
2 schedule at Good Sam which had a rotating group of
3 physicians that would be available in the same
4 amount of time as if the emergency were their own.

5 **Q. Okay. Good Sam Hospital, which is the**
6 **hospital we're referring to now, was at the time of**
7 **the death of Miss Castillo-Lopez was the only**
8 **hospital you had privileges at; correct?**

9 A. Yes. Correct.

10 **Q. Were they aware that you had resigned your**
11 **privileges and the reason for your resignation of**
12 **privileges at their St. Mary's Hospital?**

13 A. I cannot speak to what they did and did
14 not know, because I'm not on the credentials
15 committee.

16 I believe -- yes, they --

17 I responded upon terminating my privileges
18 at St. Mary's with a letter to the medical staff
19 office at Good Sam, as is what was required by the
20 bylaws. So they were notified. They were further
21 notified of the Board of Medicine agreement that I
22 had entered into. So they had at least two
23 notifications involving the same case.

24 But I cannot speak to the exact issues in
25 regards to a committee and a hospital -- I'm not on

1 the MEC --

2 Q. I'm just asking --

3 A. I'm not on the hospital privilege
4 committee.

5 Q. I'm asking you what you're aware of; in
6 other words, what you told them or what you know
7 that they received.

8 A. Right.

9 They received the notifications as was
10 required by the medical staff bylaw rules.

11 Q. Okay.

12 A. At both events, the resignation from
13 another hospital and at the Board of Medicine
14 consent agreement.

15 Q. Did anybody from administration at Good
16 Sam question you in regards to the allegations made
17 against you by St. Mary's?

18 A. I don't know how to answer that.

19 They were certainly present at a number of
20 meetings, but -- when I received the Board of
21 Medicine action and the plan for permitting me to
22 continue to practice.

23 Q. What do you mean they were present, you
24 mean present at meetings in front of the Department
25 of Medicine?

1 A. No.

2 Q. I didn't think that was the case.

3 A. Within the hospital --

4 Q. Okay.

5 A. Okay. A hospital's like a country club.

6 You have a group of people who decide who can be a
7 member and what the members are allowed to do.

8 Let's say it's a golf and tennis club. If
9 you apply for tennis privileges, then they will see
10 if you're a decent enough tennis player to be part
11 of the club. And if there's an issue involving your
12 qualifications, then those are addressed by
13 committee and there's a discussion.

14 A representative from the administration
15 attends those meetings. So at one time or another,
16 I'm certain, although I don't recall seeing who
17 might have been the person representing the
18 administration, but there was representation, they
19 were aware of my Board of Medicine action, because I
20 notified them, and they independently would have
21 been notified by the Board of Medicine. And a plan
22 was created whereby I and they were in agreement
23 what would take place in order that if I were to
24 perform surgery, that I would have met the criteria
25 for the Board of Medicine requirements.

1 Q. The reason I'm asking the way I am is
2 because both Tenet and St. Mary's hospitals are
3 owned by -- excuse me -- both St. Mary's and
4 Good Sam Hospital are owned by Tenet; correct?

5 A. Yes.

6 Q. All right. So the board at St. Mary's, a
7 Tenet hospital, was going about a decision as to
8 whether or not you had violated certain standards
9 and were, you know, going to try to remove you from
10 their hospital staff. And you chose, because of
11 what you told us was bias, that you felt was -- for
12 the reasons you felt it was present, that you chose
13 to suspend your own privileges or resign your
14 privileges?

15 A. Let me stop you there, Mr. Cohen. You've
16 mischaracterized the process at St. Mary's.

17 The administration nor the hospital had
18 made a determination --

19 Q. I didn't say that. I said they going to
20 have a hearing.

21 A. Sir, if I may finish my answer, I'll offer
22 you the same privilege.

23 May I?

24 Q. Please.

25 A. The hospital has a process. It's not up

1 to just the administration and it's not just up to
2 the medical staff. It's a collaboration whereby you
3 can go through a process if there is an issue about
4 the care and treatment of a patient. And that
5 process is intended to be, you're innocent until
6 proven by a panel, a fair hearing panel, made up of
7 members, that you have, in fact, violated one of the
8 bylaw rules or have -- or they have a concern about
9 you.

10 It never got to that stage, other than
11 they were proposing to ask me to be involved in the
12 fair hearing process.

13 I resigned because I did not feel that
14 there could be -- in a hospital with that much
15 chatter, where I was a solo practitioner and the
16 largest OB/GYN group was my competitor, if you will,
17 I chose not to go through that process.

18 **Q. Okay.**

19 A. So neither by one way or the other could I
20 say the administration alone or the hospital staff
21 alone had come to any sort of conclusion, as they
22 had not heard any facts or evidence prior to my
23 resignation.

24 **Q. And I understand that. And you told us**
25 **precisely that before, which was that you felt that**

1 because of the biases you felt for the reasons you
2 felt at St. Mary's that you would not get a fair
3 hearing?

4 A. Correct.

5 Q. Did that woman die at St. Mary's, by the
6 way, or at Wellington?

7 You mentioned Wellington before.

8 A. Right. The patient was declared dead at
9 St. Mary's.

10 Q. Okay. And the allegations that were made
11 against you at Tenet St. Mary's, which never went to
12 a hearing, for the reason you stated, were those
13 allegations known, if you know, to the people at the
14 administration at Good Sam; in other words, the
15 allegations that were created -- excuse me -- that
16 were alleged against you at St. Mary's and your
17 subsequent resignation, was the factual information,
18 if you know, known to the Good Sam people?

19 A. I have no way of knowing professionally.

20 My duty was to follow the bylaw rules at
21 the hospitals I was on staff at. I notified Good
22 Sam timely of my decision to resign while under
23 investigation. And it would have been incumbent
24 upon them to hear whatever the hospital had to say.
25 And certainly they had the opportunity to call me in

1 and have a discussion about what happened at
2 St. Mary's.

3 Q. Okay.

4 A. To my recollection, they never queried me
5 concerning the issues surrounding the other element.

6 But I could not -- you know, I'm not in a
7 position to say.

8 Since you have spoke with their
9 representatives, that may be a more appropriate
10 question to ask the hospital or the administrators
11 at Good Sam what they knew and when they knew it.

12 Q. Okay.

13 A. But it's certainly no secret, because it
14 was disclosed immediately.

15 Q. Okay. Did you when you were -- when you
16 had an obstetrical patient, any obstetrical patient,
17 after you resigned from St. Mary's and after the
18 Board of Medicine took what action it did that you
19 stipulated to in regards to your limitations during
20 surgeries ever tell your patients, any patients that
21 you had, of the limitation on you, that if this does
22 require a C-section, I'm going to have to call in
23 another doctor because I'm not allowed to do this
24 without --

25 A. And there were times that I did and there

1 were times that perhaps I didn't, depending on the
2 type of surgery that was going to be involved.

3 **Q. Right.**

4 Do you know whether you ever had a
5 discussion with Miss Castillo-Lopez in that regard
6 at any time?

7 A. I don't recall one way or the other.

8 **Q. Okay. Did you have a standard that you**
9 **used at the time that, you know, that your standard**
10 **was I would tell everyone that in case something**
11 **happens or if I'm taking you to surgery I have to**
12 **have another doctor there because of a restriction**
13 **on my privileges; did you ever discuss that with any**
14 **others?**

15 A. Of course. Of course.

16 And like, for example, in the case of
17 Mrs. Castillo-Lopez, her last baby was born at
18 St. Mary's and her aunt's babies were born at
19 St. Mary's, and her aunt was a physician in the
20 community.

21 **Q. Okay.**

22 A. And when I no longer delivered at
23 St. Mary's, I offered an explanation, if asked. Or
24 sometimes I would volunteer it if it's someone that
25 I knew that I delivered at one hospital but I'm now

1 delivering at another hospital.

2 Q. Okay. So -- but in this particular case
3 you don't recall discussing that subject matter with
4 either Miss Castillo-Lopez or Dr. Irma Lopez; is
5 that correct?

6 A. Correct, I don't have a specific
7 recollection. Which doesn't mean that it didn't
8 happen.

9 Q. Well, if -- hypothetically if there's
10 testimony which would be -- obviously not
11 Miss Castillo-Lopez, but Dr. Irma Lopez or the
12 husband, Jorge, which they testified that you never
13 had that discussion with them, you could not be in a
14 a position to counteract that, correct, contradict
15 that?

16 A. I have not seen their depositions.

17 Q. They haven't been taken yet.

18 A. Okay.

19 Q. If they were to --

20 Let me finish to make sure the question
21 comes out properly.

22 If they were to testify that they were
23 never notified by anybody, including you, of that
24 issue regarding your restriction of license and
25 privileges, that you never talked to them about

1 that, you are not in a position to deny that because
2 you don't remember one way or the other; is that
3 fair?

4 A. Well, when you say a restriction of
5 privilege, there wasn't a restriction of privilege.
6 There was simply an obligation of having a Board
7 certified OB/GYN to be with me at the time of the
8 surgical procedure.

9 Q. Isn't that's a restriction; in other
10 words, you can't operate by yourself --

11 A. The many words --

12 Q. Hang on. Let me finish now.

13 A. Okay.

14 Q. You're restricted by the Department of
15 Medicine, but also by Good Sam, you were restricted
16 from doing surgeries by yourself?

17 A. Correct.

18 Q. So that is a restriction in that regard?

19 A. In that regard, sure.

20 I apologize for that.

21 Q. And so, going back to my question, if
22 hypothetically Miss -- Dr. Lopez or -- Irma Lopez or
23 Mr. Jorge Miranda Romero, the husband, were to
24 testify that that was never discussed with them by
25 you or anybody else from Good Sam, you are in no

1 **position to refute that; is that fair?**

2 A. No, because, as you know from -- well, you
3 don't know.

4 Most of the visits by the patient she was
5 by herself. She was not with her husband and she
6 was not by Dr. Irma Lopez.

7 So to the degree that I did not discuss
8 that in front of Dr. Irma Lopez, I don't ever
9 remember seeing Dr. Irma Lopez come to my office
10 during the course of this pregnancy. And I can only
11 recall maybe one visit where I physically saw her
12 husband at the time attend a visit for an ultrasound
13 prior to the birth.

14 **Q. Okay.**

15 A. So the rest of the visits, and there's, I
16 believe, more than ten, the discussion, if it would
17 have happened, would have happened quite possibly
18 very early in her pregnancy if she were -- usually
19 it would come up when I would say I no longer go to
20 St. Mary's, and I would explain why.

21 And in regards to this patient, she lived
22 in Jupiter. Her aunt, for whom she worked for,
23 worked out of Jupiter Hospital, did all of it --
24 they both were, you know, in close proximity to a
25 hospital that they had the choice of seeing someone

1 else, someone closer to home, but made the chose not
2 to.

3 Q. They made the choice not to. But you
4 don't know if they were given the opportunity to
5 know about what had happened to your privileges,
6 correct, you don't know one way or the other?

7 A. Well, as I said, I have an independent
8 recollection.

9 But I do have a recollection of discussing
10 that I was no longer doing deliveries at St. Mary's,
11 and that was a discussion. And as to the why, I was
12 quite honest about it.

13 Q. Well, in this case?

14 You said you don't remember.

15 A. It all cases. All patients that I had
16 that I delivered at Good Sam that I prior delivered
17 at other facilities.

18 Q. Well, you told us just a little while ago
19 that you don't remember in this case one way or the
20 other whether you discussed it with this patient.

21 A. I don't remember the specific time and
22 data that would have happened.

23 Q. That's not what you said, though.

24 You said you don't remember discussing it
25 at all.

1 Now you're saying that you did discuss it
2 but you don't remember the date.

3 A. Right.

4 I'm glad it's on tape. Because that's not
5 what I said.

6 Q. It is on tape. And it's on also a court
7 reporter.

8 So tell me what you are saying, are you
9 saying that you know you did discuss it with her
10 now, or that you don't know one way or the other?

11 A. I don't have -- I probably discussed it
12 with her. I do not have an independent recollection
13 as to the date and time.

14 The question invariably came up as to why
15 aren't you delivering at St. Mary's any more. And I
16 would answer it honestly.

17 Q. What would you tell them?

18 A. I would tell them because -- that there
19 was an issue with a care of a patient at St. Mary's
20 and at the time I had restrictions that wouldn't
21 allow me to do deliveries at St. Mary's at this
22 time, and I had other restrictions at other places
23 that would involve having an assistant in the event
24 of a surgery.

25 Now, in her case we anticipated a vaginal

1 delivery. And at the time of her late pregnancy
2 there was no reason to suspect that she would need a
3 Cesarean section, let alone a hysterectomy.

4 Q. Okay. Although, in all fairness, Doctor,
5 any labor and delivery could wind up in a C-section
6 for many different reasons?

7 A. Correct.

8 Q. And even after the C-section --

9 Even after a normal vaginal delivery there
10 are also many reasons that a patient may need to be
11 taken to surgery?

12 A. That's correct.

13 Q. Did you discuss with -- can you tell us
14 that you discussed with Miss Castillo-Lopez that in
15 the event of this having to be an emergency
16 C-section or some other operative procedure you
17 would have to have another doctor come by and why?

18 A. I don't recall having a discussion in that
19 detail.

20 She was a medical assistant who had a
21 fairly substantial knowledge of surgery. I forgot
22 whether her training in Cuba was as a nurse. But
23 she knew that a surgeon, if there was a Cesarean
24 section, would not be there alone.

25 But I don't have an independent

1 recollection that I went to the detail that we're
2 going through in this deposition.

3 Q. In the administrative complaint that we
4 talked about regarding the patient at St. Mary's
5 there is a paragraph that talks about -- let me get
6 it so I can quote it exactly --

7 By the way, you were in the midst of doing
8 continuing medical education as required by the
9 settlement with the Department of Medicine at the
10 time that you took care of Miss Castillo-Lopez, do
11 you know?

12 A. Yes.

13 Q. Okay. And where were you doing that?

14 Is it an on-line thing or was it at a --

15 A. No. No. I attended some conferences.
16 No.

17 Prior to the consent order I had
18 independently taken a course, which is called the
19 simulation course, to management of postpartum
20 hemorrhage and postoperative complications. And
21 that was done at Orlando -- in Orlando, Florida at
22 Celebration Hospital in 2015, where they had these
23 highly sophisticated dummies, which were hooked up
24 to computers, and there were four major subjects,
25 one of which was postpartum hemorrhage.

1 Q. Okay. But at the time that you were
2 taking care of Miss Castillo-Lopez, based on the
3 order from May of 2017, and you took care of her,
4 obviously, just a short while afterward, were you
5 still undergoing the required continuing medical
6 education?

7 A. Yes.

8 Q. Were you also subject to any requirements
9 for community service?

10 A. No.

11 Q. Had you been previously with the Board of
12 Medicine, had they previously demanded that you
13 perform a number of hours of community service on a
14 different case?

15 A. Yes.

16 Q. How many times did that happen?

17 A. Once.

18 Q. Okay. And how many hours did they require
19 of you, do you recall?

20 A. 200 hours.

21 Q. And that was the case if I'm -- about
22 2004?

23 A. Yes, sir.

24 Q. And is that the case where a D and C was
25 performed by you for a fetus that had died in utero;

1 is that the -- that case?

2 A. Yes.

3 Q. Okay. And my understanding from reading
4 the complaint in that case is that you had done --
5 you had determined that the child was not viable,
6 was dead, the fetus, and that you were going to
7 perform a D and C to remove the fetus?

8 A. Correct.

9 Q. And that subsequent to the D and C the
10 patient involved actually passed -- a numbers of
11 weeks subsequent, that patient actually passed a
12 fetal head and fetal arms and legs out of her
13 vagina?

14 A. Correct.

15 Q. Okay. So can you explain how that
16 happened, how you did a D and C on a fetus and
17 didn't actually see the fetus?

18 A. Well, just immediately prior to performing
19 this operation the patient had had an ultrasound
20 done at Palm Beach Gardens Medical Center. The
21 fetal size by the radiologist was between 12 and
22 13 weeks size.

23 Q. Okay.

24 A. And I used a closed container technique
25 with a large bore suction catheter. So all of the

1 parts would not be recognizable, since they would
2 partly be in a plastic container and they may have
3 been in some capacity crushed by the suction and
4 turning process of how the -- it's like a vacuum
5 cleaner that you turn and materials get sucked out.
6 So you would not necessarily identify all of the
7 parts that are contained within the container. And
8 after that I took out remaining parts using a Winn
9 forceps as part of my surgical procedure. So all
10 the parts were not identified.

11 **Q. Okay. So do you send that to pathology?**

12 A. Yes.

13 **Q. And did they identify the parts?**

14 A. They did not identify all of the parts,
15 no.

16 **Q. Did you call the -- did you --**

17 **Were you therefore concerned that you may**
18 **not have gotten everything?**

19 A. That was one concern.

20 The other concern was that since there
21 were two places where there was specimens, one was
22 in a -- again, the canister of suction contents and
23 then the second one from where I teased out tissue
24 and materials using a Winn forceps, there were
25 actually two collections of samples. It could have

1 also been nursing error, where they only submitted a
2 portion.

3 My explanation and my understanding was,
4 it could have been just a portion of the specimen
5 was submitted and not the total specimen was
6 submitted.

7 Q. Well, what came out of the lady a number
8 of weeks later was a female fetus with a normal
9 head, neck, abdomen, legs and back, all those parts,
10 which is -- sounds like most of the fetus; right?

11 A. Correct.

12 Q. And when you do a D and C and the baby --
13 the fetus is expelled in the way you, you know,
14 talked about it, how you do it, how is it that you
15 would not see the head or the arms or legs or back,
16 spine of the baby, how is that possible?

17 A. Because one of the techniques that can be
18 used is involving a suction device, and that suction
19 device can macerate, it chops off the parts so they
20 would not be identifiable as individual parts.

21 Q. Okay. The Department of Medicine looked
22 into that case and found that you did deviate from
23 the standard of care in your performance of that
24 D and C and follow-up care; correct?

25 A. Yes.

1 Q. And that was in 2004, as I said.

2 And that agreement -- there was a consent
3 agreement in that case, too?

4 A. Correct.

5 Q. Okay. And do you agree in that case that
6 you fell below the standard of care, or was it the
7 same thing as the 2017 decision, do you recall?

8 A. I made the decision to enter into a
9 consent agreement. And I believe the same paragraph
10 and language is substantially the same, where I
11 neither denied nor admitted that --

12 And, again, if you'll share it with me,
13 I'll be happy to read it into the record.

14 Q. Sure.

15 A. "The Respondent," that's me, "waives
16 probable cause and the filing of administrative
17 complaint by the Department" -- I guess that could
18 be interpreted that they didn't file an
19 administrative complaint -- "which would have
20 charged him with a violation." And that -- this is
21 on page 340.

22 And on page 341 it says "Respondent
23 neither admits nor denies the allegations of fact
24 contained in the draft administrative complaint for
25 purposes of these proceedings only."

1 So we could say that I waived the probable
2 cause and that they never filed an administrative
3 complaint by the Department, according to -- that's
4 what the language says on page 340.

5 **Q. But they were going to and they showed you**
6 **a draft of it and that's when you settled it?**

7 A. Correct. That's right.

8 **Q. Okay.**

9 A. That avoided the filing of an
10 administrative complaint.

11 **Q. Right.**

12 A. And I neither --

13 **Q. And that was the one where they -- you**
14 **also stipulated that you would be required to**
15 **perform 200 hours of community service within two**
16 **years from the date of the final order; correct?**

17 A. Yes.

18 **Q. Now, in the complaint of 2017 -- not the**
19 **complaint, but the final disposition of the case in**
20 **2017, which I've misplaced somewhere -- there was an**
21 **issue raised -- there were words raised about -- let**
22 **me get it exactly. I don't want to mispronounce it.**

23 MR. COHEN: Let's go off the record for a
24 second.

25 (Whereupon, an off the record discussion

1 was held.)

2 BY MR. COHEN:

3 Q. Okay. One of the other requirements, sir,
4 of the 2017 order was that you should undergo an
5 evaluation by the Florida CARES, capital -- all
6 capitals C-A-R-E-S, a Board or a board approved
7 equivalent evaluator.

8 What is that, Florida CARES?

9 A. Florida CARES, basically, you go in and
10 you do two or three day it's like a Board
11 recertification examination, where they -- it's
12 divided up into four different parts. One part is
13 that you do a physical exam on patients that they've
14 selected that have known disorders, so that they can
15 evaluate your ability to appropriately evaluate a
16 patient. Another part might be questioning.
17 Another part is a chart review. And then the fourth
18 part, I believe, is like -- they make you take a
19 number of psychological tests, personality tests,
20 MM -- an MMP.

21 Q. Right.

22 A. Minnesota --

23 Q. Multi whatever.

24 A. Right; right; right.

25 Q. In this case, do you know what type of

1 **evaluation was done, if it was ever done?**

2 A. No, I haven't done it. They didn't put a
3 time limit to have it done.

4 Q. Okay. This is now -- this was ordered, as
5 I said, in May of 2017, and we're now in January of
6 2019.

7 Are you still under the restrictions that
8 were imposed in 2017 by the board?

9 A. Yes.

10 Q. Okay. Have you attempted to get those
11 restrictions released in any way?

12 A. Not yet, because I need to complete the
13 Florida CARES or equivalent evaluation.

14 Q. Is there a reason you haven't done that?

15 A. Well, yes. There were a number of
16 reasons. One reason had to do with the death of my
17 father last year --

18 Q. Sorry.

19 A. -- and resolving his estate.

20 There were family reasons that
21 predominantly pushed it off.

22 Q. So you have not yet --

23 I don't want to go into your family
24 issues, your personal issues.

25 But suffice to say, you have not attempted

1 yet to go be evaluated by Florida CARES?

2 A. Correct.

3 Q. And you don't know --

4 Do you know what type of evaluation in
5 this case -- the order in this case was going to be
6 required; in other words, was there a specific
7 evaluation that they were sending you for?

8 A. The four elements that --

9 Q. All four?

10 A. Well, I think for discussing this with
11 others that have gone, they've generally at a
12 minimum all four elements are reviewed. Then they
13 go over the results of the review with you, and then
14 they may make -- you know, they may say he needs
15 more education in one area or another. If they
16 think that you have an impairment problem, they may
17 ask you to get your eyes checked or go to alcohol
18 rehab or whatever they think the impairment is.

19 Q. Was there any impairment --

20 Did you have any impairment that was
21 raised by the board or by anyone else?

22 A. No.

23 Q. Okay.

24 A. No, not to my knowledge.

25 Q. Okay. Well, that's what I'm asking is

1 your knowledge.

2 A. No.

3 Q. Do you have a current plan to go to
4 Florida CARES to be evaluated in the way that they
5 evaluate you?

6 A. I have -- it is my intention to do that.
7 Do I have a specific date and time?

8 Q. Yes.

9 A. Not as of yet, no.

10 Q. Okay. So currently -- going back to
11 that -- currently you have no privileges to deliver
12 babies at hospitals?

13 A. Correct.

14 Q. Do you have any hospital privileges at
15 all?

16 A. No.

17 Q. Okay. So you perform GYN procedures and
18 you perform obstetrical procedures.

19 Let's go through those.

20 Some GYN procedures require the patient
21 being admitted to the hospital, I take it?

22 A. Correct.

23 Q. And if that is necessary, what do you do
24 with the patient now?

25 A. I refer them to other doctors that can

1 perform them.

2 Q. Okay. When was it, by the way, that Good
3 Sam --

4 In the case of Good Sam, did the -- who
5 was it that told you that they were not going to
6 keep your privileges in place?

7 A. I was the one, because it was time for me
8 to renew my clinical privileges and I elected not to
9 submit a reapplication for privileges.

10 Q. And you --

11 A. But just prior to that I had a
12 precautionary suspension, which is typical when
13 there is a maternal death. And, once again, it
14 would have been an internal process where they would
15 have had the case evaluated independently.

16 Q. And you didn't want to go through that
17 procedure for what reason?

18 The procedure that you would have to go
19 through to get your license reinstated from
20 suspension, why did you choose not to go through
21 that?

22 A. Okay. Let me answer it this way, it's not
23 a licensing issue.

24 Q. Privileges.

25 A. It is a privileging issue.

1 And the difference is, the hospital has no
2 licensing power, to my knowledge.

3 Q. I understand that. I used the wrong word.

4 Let me rephrase my question so you can --

5 I used the wrong word.

6 Your license -- your privileges to
7 practice at Good Sam were temporarily suspended
8 pending an investigation, I take it?

9 A. Correct.

10 Q. And you chose rather than to go through
11 the investigation process and be subject to whatever
12 restrictions they would place or asking you to leave
13 the staff, rather than that you chose to resign your
14 privileges; is that correct?

15 A. Correct.

16 Q. Okay. Why?

17 You told us why at St. Mary's.

18 Is it the same thing at Good Sam, that you
19 felt it was biased against you?

20 A. No. There were several things that had
21 changed between those times. One thing that had
22 changed is, there is a new model of medicine, where
23 many doctors quit doing things at hospitals. For
24 example, Dr. Lopez, the internal medicine doctor
25 who's related to the deceased, sometimes she sends

1 her patients to be admitted to the hospital, but yet
2 it's a hospitalist service that takes care of those
3 patients while they're in the hospital.

4 **Q. Right.**

5 **But I'm talking obstetrics and gynecology.**

6 **A.** That's the trend that has --

7 The same trend is happening in my
8 specialty, where many doctors have chosen to
9 contract out with an OB/GYN hospitalist group, where
10 you can focus your energies and times on office
11 care. And if a patient needs hospital care, the
12 patients will present themselves to the hospital by
13 contract with this group, and they would take care
14 of your patient. And then when they're finished
15 with whatever it is -- say the woman is pregnant,
16 they'll deliver the baby -- they'll round on the
17 patient, deliver the mother, and send the mother
18 back to you for postpartum care.

19 **Q. Tell us in Palm Beach County, if you**
20 **would, what hospitals do that?**

21 **A.** Bethesda, which I don't go to; Palms West;
22 JFK in Lantana. Those are the three that I know
23 that the group that I contracted with provide
24 services.

25 **Q. Okay.**

1 A. There's several in South Florida.
2 That's -- those are just the ones that come to mind.

3 I know that there's hospitalist contracts
4 out in other places, for example, at Lakeside
5 Hospital there's a hospitalist service.

6 **Q. There are hospitalist services all over**
7 **the state. But specifically OB/GYN hospitalists?**

8 A. That's what I'm talking about. I'm
9 talking about exclusively OB/GYN hospitalists
10 services.

11 **Q. So you take care of a mother for eight,**
12 **nine months in your office, and she's told that when**
13 **it comes time to delivery they'll be some new doctor**
14 **that will see her at the hospital?**

15 A. Correct. We give them a picture -- they
16 have a pamphlet of the panel of doctors that would
17 be on call. The same group, OB/GYN Hospitalist,
18 it's a national group, I think it's out of South
19 Carolina, if I'm not mistaken, the national
20 headquarters, and they do this in a lot of places.

21 **Q. And the name of that group is?**

22 A. OB/GYN Hospitalists -- OBGHG. So I think
23 is OB/GYN Hospitalist Group. But I think they go by
24 OBG -- OBGHG.

25 **Q. Okay. So Good Sam was not one of those**

1 hospitals that went that direction?

2 A. No, Good Sam up to this point has not.

3 But they have been interviewed -- I mean,
4 they've considered it on a couple of occasions and
5 have elected not to go that route.

6 Q. Okay. And in that regard, the question
7 that brought that about was, why did you decide not
8 to contest the suspension of your license -- of your
9 privileges at Good Sam; was it the same reason at
10 St. Mary's, where you thought there was bias, or was
11 there a different reason at Good Sam?

12 A. Okay. I'm going to ask you to rephrase
13 the question because it seemed compound.

14 Q. At Good Sam -- at St. Mary's -- Tenet
15 St. Mary's you told us why you resigned your
16 privileges and what was going on, that you thought
17 there was a bias, correct, in regards to if you had
18 gone through the entire procedure of hearings at
19 St. Mary's there were certain biases against you,
20 for the reasons you stated earlier, and you felt it
21 was easier just to resign; is that correct?

22 A. I think you mischaracterized it.

23 The reason is, I did not see how it was
24 possible, when the head of the trauma service and
25 the head of the hospitalist group for internal

1 medicine, who are now parties in a lawsuit, would
2 not have rancor and finger pointing towards me and
3 allow me to have a fair hearing.

4 As it comes out in that sort of a review
5 process there are biases that are also of a
6 political nature from competing OB/GYN groups.

7 I'm a solo practitioner.

8 **Q. That's why I put it the way I put it.**

9 A. So in St. Mary's that was the problem.
10 Okay.

11 At Good Sam the decision was made based on
12 several factors, none of which were related to the
13 ones that were involved in St. Mary's.

14 **Q. What were the factors at Good Sam where you**
15 **did not contest the suspension of your license -- of**
16 **your privileges?**

17 A. There were many. Some personal.

18 **Q. Okay.**

19 A. I was heading in that general direction
20 anyway, because in general I would be on call more
21 often than I would if I joined or contracted with
22 the OB/GYN hospitalist group. That is the most
23 common reason.

24 It's the same reason why internal medicine
25 doctors contract with internal medicine hospitalists

1 groups, it's a trend that is very popular now, and
2 it's one of the more popular trends in obstetrics
3 and gynecology because --

4 Q. How popular is it with the patient?

5 I would imagine a woman who is going to
6 give birth, going through a pregnancy and give
7 birth, usually gets pretty attached to their
8 obstetrician or the group of obstetricians that
9 they're seeing. And instead of just, okay, now my
10 water broke, I have to go to the hospital, I'm
11 meeting a doctor for the first time that's going to
12 do that delivery, how do your patients handle that?

13 A. Well, they have -- the patients are
14 advised to go to the hospital and meet with the
15 hospitalist before they deliver. That's one thing.

16 The second element is, that medicine has
17 changed in its complexity. If you were to deliver
18 at St. Mary's Hospital, there are at last count
19 maybe 50 or 60 doctors that have hospital privileges
20 there, the largest majority of them in a group
21 practice. You have about a one in seven to one in
22 ten chance that your favorite obstetrician, the guy
23 that you wanted to go into that group, will be on
24 call when it's time for you to deliver. So
25 statistically speaking the days of the doctor that

1 you saw for your entirety of prenatal care is the
2 doctor that you will see at delivery.

3 And let me just say this, one of the
4 largest referral places for my own practice is the
5 large OB/GYN groups, because the patient's see each
6 doctor one time. And the largest group they see the
7 patient -- I mean, they see a doctor or a nurse
8 practitioner only one time. And then it's time to
9 have your baby. Because they're a big group, they
10 may have ten doctors, mid levels. And so by the
11 time they're done rotating through all the
12 providers, they're not going to get that one that
13 they most like.

14 So that trend is gone.

15 **Q. In your case they can't see you in the**
16 **hospital because you have no privileges?**

17 A. In my case that's correct.

18 **Q. Do you tell your patients that you have no**
19 **hospital privileges and that you cannot under any**
20 **circumstance deliver them at a hospital?**

21 A. Yes.

22 **Q. Okay. Do you still take care of**
23 **obstetrical patients?**

24 A. Yes.

25 **Q. Percentage-wise has that practice gone up,**

1 stayed the same or gone down, since your license
2 was -- excuse me -- your privileges were suspended
3 at Good Sam?

4 A. I'm going to ask you to rephrase the
5 question, please.

6 Q. The obstetrical part of your practice, has
7 the -- percentage-wise has it gone up, stayed the
8 same or gone down, since you had your privileges
9 suspended at Good Sam?

10 A. I believe that it's gone down just a
11 little bit.

12 Q. Okay. Gynecologic procedures that need to
13 be done in the hospital, the same issue, you refer
14 to that group that you have a contract with?

15 A. No, not necessarily.

16 In that regard, it depends on the type of
17 surgery a patient may need.

18 Gynecologic patients still come to my
19 practice for annual examinations, pap smears,
20 problem, you know, infections, other general
21 gynecologic concerns.

22 In the event that they need surgery, it
23 depends on the type of surgery they need. In
24 northern Palm Beach County we have certain doctors
25 that are experts at robotic surgery. Not all the

1 doctors perform robotic surgery. I do not perform
2 robotic surgery. Some of the doctors are
3 specialized in problems with the urinary bladder,
4 urogynecologists. Those patients are sent to the
5 urogynecologist that I think do the best work. The
6 patients -- some patients may have a malignancy or a
7 pre-malignancy issue, and those I send to selected
8 OB/GYN gynecologic oncologists, of which there's
9 several groups in town now.

10 So I segregate them out based on need and
11 who I think will deliver the services that would end
12 up with the best outcome.

13 Q. The delivery of Jorge Jason Miranda,
14 that's Miss Castillo-Lopez's little boy that was
15 born on the day she died, technically the day before
16 she died, because she died in the early morning
17 hours of the next day, is that the last baby you
18 delivered?

19 A. Yes.

20 Q. And were you immediately suspended after
21 that by --

22 A. Yes. The next day, I believe. Yes, I
23 think it was the next day, the following day.

24 Q. And an administrative complaint has been
25 filed against you for that case, this case, by the

1 Department of Health?

2 A. Correct.

3 Q. And is that still pending?

4 A. Yes.

5 Q. Do you know what stage it's at, if I can
6 put it that way?

7 A. The last I spoke to my attorney, they were
8 negotiating the terms of a settlement.

9 Q. Are the proposed terms that you know of,
10 do they include suspension of any operative
11 privileges anywhere?

12 A. No.

13 Q. Do they exclude the delivery of children?

14 A. They do not.

15 Q. What do they exclude, proposed, anything?

16 A. I can't -- to my knowledge, they're not
17 looking at any suspension whatsoever.

18 Q. So are you saying that they are going
19 to --

20 Are there any disciplinary procedures that
21 you're aware of that they have proposed?

22 A. Again, it's an active negotiation.

23 I believe it's going to be -- there's
24 going to be a fine and there are going to be
25 probably CME's involved. But I've been told as of

1 the last negotiation discussion, they're not talking
2 about suspending.

3 I'm already on an obligation to have an
4 OB/GYN present at the time of a procedure.

5 Q. There's a board of probation I think that
6 they have, a separate board of probation, the call
7 it --

8 A. Right.

9 Q. -- that has to decide whether you come off
10 of that or not.

11 A. Again, there's many details of the process
12 that you know better than I.

13 Q. Okay. But -- Okay.

14 A. But no, suspension is off the table.

15 MR. COHEN: Okay. Let's take a five
16 minute break, if we can. We've been going for
17 awhile.

18 THE WITNESS: Okay. Sure.

19 (Whereupon, a short break was taken.)

20 BY MR. COHEN:

21 Q. Okay. Now, in addition to the complaint
22 that was made to the Department of Medicine which
23 resulted in your -- the suspension of your operative
24 privileges without another supervising OB/GYN in
25 2017, did that -- we talked about the woman who died

1 from bleeding -- ultimately from bleeding, and that
2 the other physicians involved that you told -- the
3 facts that you basically told us about.

4 Was there another woman that was subject
5 to that same complaint?

6 A. I'm not sure I understand your question.

7 Q. Was it one patient that was being
8 complained about or was it two patients that were
9 being complained about?

10 A. It was -- that involved one patient who
11 was transferred from one hospital to another
12 hospital.

13 Q. Okay. Which was -- which hospitals?

14 A. She was transferred on the advice of
15 Dr. Goad, the general surgeon, who did not come to
16 the bedside and evaluate the patient, from
17 Wellington Regional Medical Center to St. Mary's
18 Medical Center.

19 Q. Okay.

20 A. So once -- the same patient transferred
21 from one hospital to another on the advice of the
22 consulting surgeon.

23 Q. Were there any other patients that were
24 subject to that same disciplinary proceeding in
25 front of the Department of Health?

1 A. No.

2 Q. How many times that you know of have
3 patients died under your care after or during birth?

4 A. Two.

5 Q. The two we mentioned already.

6 Are there -- were there ever any others?

7 A. I did care for a patient that my partner
8 took care of, delivered, that I performed CPR on,
9 who died. But I think it would be a gross
10 exaggeration to say that I cared for her, other than
11 in her terminal moments.

12 Q. All right. And what partner was that?

13 A. Sebastian Kent.

14 Q. So the two patients would have been the
15 one that we mentioned from 2014 where the 2017 order
16 resulted in restriction of your privileges and the
17 other one would be Mr. Castillo-Lopez?

18 A. Correct.

19 Q. Is there any allegation in a case called
20 Ligonge, L-I-G-O-N-G-E?

21 A. Not against me, that I'm aware of.

22 Q. Okay.

23 A. Does she have another name?

24 Or I would know, because I've not been
25 served.

1 Q. I'm just asking if you're aware of any.

2 A. No.

3 Q. A case by a patient named Buchanan?

4 A. Yes.

5 Q. And what is that case -- what is the
6 current position of that case?

7 A. Judith Buchanan. That case was settled.
8 She had appendicitis. I do not perform
9 appendectomies during pregnancy.

10 Q. How were you involved?

11 A. The surgeon --

12 I was her primary obstetrician.

13 I called the surgeon right away to
14 evaluate her. And he allowed her to stay in
15 whatever condition she was in overnight and did not
16 operate until the following afternoon.

17 Q. And she died as a result?

18 A. No. She's alive.

19 Q. She's alive. Okay.

20 A. She's alive.

21 Her baby was born prematurely. And I
22 think he died of prematurity.

23 But no. Judith Buchanan is alive and
24 well.

25 Q. And has an action been brought against you

1 **for that?**

2 A. Not -- well, it was settled in -- yes,
3 there was a lawsuit. This is going back, I think it
4 was the '90s.

5 **Q. Right. Okay.**

6 A. Yes, there was a lawsuit. And we settled
7 that lawsuit.

8 **Q. Okay. Then there's a case also called**
9 **Dominic Shelton versus you and others.**

10 **Are you aware of that case?**
11 **2012 that it was filed.**

12 A. Yes. I think I was released from that
13 lawsuit, if that's the one I'm thinking about.

14 That was the baby that was -- the baby
15 that was born --

16 **Q. A brain injured child.**

17 A. Thirty-three weeker, who developed spastic
18 cerebral palsy.

19 Yes, I was released from that case.

20 **Q. And where was that baby delivered?**

21 A. That baby was born at St. Mary's.

22 **Q. Okay. There are some pleadings in that**
23 **case which we pulled off the Internet in regards to**
24 **Tenet St. Mary's had a motion in limine regarding**
25 **the status of you as a former defendant in this**

1 action; in other words, they didn't want the
2 Plaintiffs to be able to raise that you had been
3 suspended in the Shelton -- not in the Shelton case,
4 but they didn't want it brought up in the Shelton
5 case.

6 A. I was not suspended in the Shelton case.

7 Q. I said they filed a motion about that,
8 that you had been suspended previously, and they
9 didn't want that brought up in front of any jury in
10 that case.

11 A. You mean --

12 No. I had been suspended in a case
13 subsequent to Shelton, not before Shelton.

14 Q. But the case that you were suspended, is
15 that the 2014 case?

16 A. Yes.

17 Q. And this --

18 A. This was a 2012 case.

19 Q. Right.

20 Were you suspended immediately?

21 A. In 2014?

22 Q. Yes.

23 A. Yes. When there's a maternal death, it's
24 customary to do precautionary suspension.

25 Q. Okay.

1 A. Pending an investigation to evaluate --
2 you know, to do a root cause analysis, as they say
3 in risk management.

4 **Q. Okay. Did -- what happened to the woman**
5 **in that case, Shelton?**

6 A. The patient was admitted with premature
7 rupture of membranes at approximately 33 weeks
8 gestation. During the course of having an IV line,
9 a central IV line flushed with a medicine called
10 FlowCath, she had a respiratory arrest.

11 At the time of her respiratory arrest
12 there was a hospitalist physician, an OB/GYN
13 hospitalist, who presented to her room, evaluated
14 the patient, but did not write a note.

15 The rapid response team noted that the
16 patient -- that the physician came to the bedside
17 and left while there was a ten minute active
18 deceleration.

19 I was notified --
20 She was my patient.

21 **Q. All right.**

22 A. I was notified. And I was at Good
23 Samaritan, which is a few miles, maybe two, three
24 miles away, and rushed, and asked the operating room
25 to be set up for a Cesarean section.

1 And I immediately arrived and performed,
2 when the patient was transported to the operating
3 room, an emergent Caesarean section, and delivered
4 the baby.

5 I was never -- I was never suspended. No
6 cause for action on the part of the hospital was
7 ever found for my care and treatment.

8 There was a concern and I believe other
9 issues with the other OB/GYN, who was, in fact, an
10 OB/GYN hospitalist, with their lack of timely care
11 in the face of a nonreassuring fetal heart rate
12 pattern by a prolonged fetal heart rate deceleration
13 almost ten minutes duration.

14 **Q. Okay. And -- Okay. And that baby wound**
15 **up with -- the allegation was that that baby was**
16 **brain damaged as a result?**

17 A. Correct.

18 **Q. And did you testify in that case by way of**
19 **deposition?**

20 A. Yes.

21 **Q. Did you give any sworn testimony in front**
22 **of the Department of Medicine on the cases we talked**
23 **about so far?**

24 A. If you would list the cases, I would say
25 yes or no to each one, because we've talked about

1 many different cases and I don't want to be
2 confused.

3 Q. There was the one at St. Mary's that lead
4 to your suspension.

5 A. That would be the Perez case.

6 Q. Right.

7 A. Okay.

8 Q. Did you testify in any proceeding in that
9 case?

10 A. Yes. In a deposition I have.

11 Q. Okay.

12 A. As well as in front of Board of Medicine
13 when we did the --

14 Q. Okay. And in the Shelton case you
15 testified, or did you testify?

16 A. Okay. The Shelton case, I believe I gave
17 a deposition.

18 Q. Right. Here it is. I just found it.

19 A. Yes.

20 Q. Here it is.

21 And in the -- in this case in front of the
22 Board of Medicine have you testified?

23 A. It has not --

24 Q. Meaning the case involving the death of
25 Onystei Castillo-Lopez.

1 A. No. It has not gone to that point yet.

2 **Q. Okay. You do expert witness testifying?**

3 A. I do.

4 **Q. And tell me about that, as far as**
5 **frequency, you know, plaintiff versus defendant, all**
6 **those questions you get asked.**

7 A. I've been doing it since the time my
8 sister was a medical malpractice defense attorney
9 representing St. Mary's in the early '90s. I
10 initially did mostly defense work, because most of
11 her friends were defense attorneys and then they may
12 have been turned into plaintiff's attorneys. So
13 I've been doing it for 26 years, something in that
14 range.

15 **Q. Okay. And how often?**

16 A. Twenty-six, 27.

17 **Q. How often do you do it?**

18 A. I don't know the exact number of cases
19 I've done overall. Probably -- I've reviewed
20 probably over a thousand cases.

21 The majority of the time the physician has
22 done nothing wrong and there's an outcome that's
23 less than what people had expected. So most cases I
24 find for -- the causation to be something other than
25 physician negligence.

1 Most of the cases are referred to me now,
2 I'd say 99 percent -- between 95 and 99 percent of
3 cases are plaintiff cases, where plaintiff's
4 attorneys has asked me to opine as to the care and
5 treatment. I've been a standard of care expert for
6 some time.

7 **Q. And currently which lawyers locally do you**
8 **get retained by?**

9 A. Well, in the State of Florida, Morgan and
10 Morgan. I most recently had been retained by -- I'm
11 trying to think of the names. After awhile they run
12 together.

13 **Q. Searcy, Denney ever?**

14 A. I have in the past, not recently.

15 **Q. Okay.**

16 A. Probably in the '90s I reviewed a case or
17 two for them. But not local cases, cases out of
18 Florida.

19 It will come to mind. I'm bad with names
20 sometimes.

21 **Q. Okay. Any defense lawyers you recall**
22 **testifying on behalf of?**

23 A. I've reviewed cases for Chimpoulis' firm.

24 **Q. Okay. When was the last time?**

25 A. It's been awhile. Again, probably in the

1 '90s.

2 Q. Go ahead.

3 A. I think it's Alex Rodriquez and Associates
4 in Miami. Maria Tejedor in Orlando. Those are the
5 names that come to mind.

6 Q. Okay.

7 A. Ken Levine in Boston, Massachusetts. I
8 can't remember the first name of this lawyer, I
9 think his name is Getz, G-E-T-Z, in Maryland,
10 Baltimore, Maryland.

11 Q. Okay. How many times have you been named
12 in a medical -- in a malpractice case?

13 A. I don't know.

14 Q. When you say you don't know, you don't
15 know because you don't recall or because there's a
16 lot that you don't remember the number or is it --
17 what is the reason?

18 A. I haven't ever actually counted.

19 I imagine it's less than ten and perhaps
20 more than seven.

21 Q. Okay.

22 A. Because some cases get settled in the
23 presuit period, and I'm not sure if you would define
24 that as a lawsuit or not. Some I'm released during
25 the case, as happened in the 33 weeker, because they

1 ultimately find that I presented no liability.

2 I had no liability in the case.

3 So I believe it may be more than seven and
4 less than ten over my 30-something year career.

5 **Q. How many judgments, if any, have been**
6 **rendered against you after a trial?**

7 A. Okay. I think we've settled during trial.
8 I do not know that I've had ever a jury trial go to
9 a judgment against me.

10 **Q. Okay.**

11 A. And you asked me a question, if I may add,
12 that may cause me to draw a legal conclusion out of
13 my expertise as an OB/GYN.

14 **Q. Are you currently listed to testify in any**
15 **cases as an expert witness?**

16 A. Yes.

17 **Q. And can you tell me how many and when?**

18 A. I cannot, because what happens is, many
19 cases settle and at various times, and some
20 attorneys are very kind to let me know so I can
21 release space on either a computer or a collection
22 of papers and storage and some don't.

23 **Q. Okay.**

24 A. Many cases take years to resolve. So I
25 don't know how many cases I'm actively named as an

1 expert upon.

2 Q. Okay. Do you have one coming up for
3 testimony at trial any time soon?

4 A. I think there's one in February that's
5 coming up. It's not a medical malpractice case.
6 It's an office -- office staff negligent case in, I
7 believe, Tampa.

8 Q. Medical office, I take it?
9 Medical office?

10 A. Yes. An OB/GYN medical office, where a
11 medical office failed to timely get a patient in to
12 be evaluated by a perinatologist, thus preventing
13 her from making or having the option of a child
14 being born with a very serious medical condition.
15 Wrongful life case.

16 Q. Have you ever testified in a case
17 involving the death of a mother during or
18 immediately after delivery, as an expert witness?

19 A. Yes.

20 Q. Tell me, if you know, how many times,
21 approximately?

22 A. I don't know the exact number.
23 Most recently one settled I think in
24 December.

25 Q. And that was on behalf of the plaintiff

1 **that you testified?**

2 A. Correct.

3 **Q. And you gave a deposition in that case?**

4 A. No.

5 **Q. What was the name of that case, do you**
6 **recall?**

7 Or the names of any of the cases where you
8 **testified where a woman --**

9 A. I believe that that attorney's name is
10 Cohen, Weinstein and Cohen.

11 **Q. Okay. Any others that you recall where a**
12 **woman died as a result -- during or immediately**
13 **after her delivery?**

14 A. Yes. I'm sure I'm done at least perhaps
15 four or five that come to mind. I mean, none
16 recently, other than there were two that I know that
17 happened in Broward.

18 **Q. Tell us a little bit about your medical**
19 **background, where did you go to medical school?**

20 A. The Medical College of Georgia in Augusta,
21 Georgia.

22 **Q. Where did you do your internship and**
23 **residency?**

24 A. Emory University affiliated program in
25 Atlanta, Georgia.

1 **Q. Are you still Board certified in**
2 **obstetrics and gynecology?**

3 A. I am through December of 2019.

4 **Q. Do you plan on recertifying?**

5 A. I just got recertified. I've been
6 recertified continuously since the year 1990. I'm
7 going on my what, 30th year almost.

8 **Q. In this particular case have you**
9 **reviewed -- what have you reviewed?**

10 A. I have reviewed the medical records of
11 Ms. Castillo-Lopez, including my office records for
12 her prenatal care for this index pregnancy, and the
13 hospital records at Good Samaritan Medical Center
14 for her delivery that's the subject of this
15 delivery. I've also gone back and looked at the
16 ACOG -- American College of OB/GYN, of which I'm a
17 member, some information about the management of
18 postpartum hemorrhage according to one of their
19 guidelines.

20 And, as I mentioned, in 2015 I took a
21 simulation course that dealt with the management of
22 postpartum hemorrhage using dummies, computerized
23 dummies.

24 **Q. Okay. Anything else that you reviewed in**
25 **this case for this case?**

1 A. Other than what I typically and normally
2 would review on an ongoing basis.

3 **Q. That's why I said for this case**
4 **specifically.**

5 A. Well, again, the subject of postpartum
6 hemorrhage and maternal mortality is a big subject.
7 There's a new big impetus to prevent mortality due
8 to postpartum hemorrhage. It's the most common
9 cause of maternal mortality, despite all the changes
10 in blood banking and so forth. There have been
11 several recent articles that headline some of the
12 journals that I subscribe to and some what we call
13 throw away journals.

14 **Q. Do you fault anybody for the death of**
15 **Miss Onystei Castillo-Lopez?**

16 A. No.

17 **Q. Including yourself?**

18 A. Absolutely not.

19 **Q. And her cause of death was what?**

20 A. Well, that's the subject for someone else
21 to opine. I'm not an expert on mortality.

22 I think she certainly died as a
23 complication of her postpartum hemorrhage.

24 **Q. Did you read the autopsy?**

25 A. I did.

1 **Q. Did that tell you what she died of?**

2 A. No, because I don't think that the -- that
3 that pathologist, which is, I think, the assistant
4 medical examiner of Palm Beach County, who wrote
5 that opinion, may have the full understanding of
6 shock.

7 **Q. Okay. Do you not think she was in shock**
8 **by the end of her life?**

9 A. Again, I'm not sure that I've finished my
10 full opinions as to her proximate cause of death.

11 I saw no evidence of a pulmonary embolism.

12 But the manner in which she died did not
13 seem to clearly fit the picture of an acute shock,
14 in my opinion.

15 **Q. The autopsy showed no evidence of**
16 **pulmonary edema, did it?**

17 A. Pulmonary edema?

18 **Q. Pulmonary embolus. Excuse me.**

19 A. Correct.

20 **Q. What it did show evidence of was that the**
21 **lady had retained pieces of uterus, retained**
22 **cervical -- cervix, and that she basically bled to**
23 **death, which resulted in shock and death.**

24 **That's what the autopsy found; correct?**

25 A. That's the description. But I think it's

1 in error for a lot of very good scientific reasons.
2 The first one of which, this patient did not
3 manifest any vaginal bleeding sufficient enough that
4 would have explained shock; that the pathology
5 report failed to note that the supracervical
6 hysterectomy was consistent with, again, some
7 guidelines in the American College's postpartum
8 hemorrhage management protocol, which is, it's up to
9 the decision-making and opinion of a surgeon whether
10 or not to take out or leave the cervix based on what
11 would be most expeditious in light of their medical
12 status at the time of the emergency hysterectomy.

13 Furthermore, the procedure that was
14 performed that allowed a part of the lower uterine
15 segment and the cervix to remain, there was the same
16 type of suturing that is recognized as a form of
17 controlling a postpartum hemorrhage; in other words,
18 the remaining portion of the upper part of the
19 cervix and the lower part of the uterus had Z line
20 suturing, as you would sometime do if you wish to
21 retain the uterus. And that's consistent with
22 something that could be done.

23 It's also further noted in her operative
24 note and the note of the anesthesiologist that at
25 the conclusion of the case that there was hemostasis

1 intra-abdominally.

2 Some of the findings that the pathologist
3 commented on, for example, the presence of blood in
4 two areas of the patient's body, are common when you
5 use the mechanical CPR device in a fresh
6 postoperative patient, because the amount of
7 pressure that's generated by the compression of the
8 electronic CPR device can freely exceed the tensile
9 strength of the suturing material that's holding a
10 fresh postoperative patient. And in and of itself,
11 I'm not quite sure that's the volume of blood in
12 someone who just recently had been transfused to
13 have caused her to go into life-threatening shock.

14 **Q. Then what did?**

15 A. I said on -- I have not finished my
16 opinion or investigation as to her cause of death.

17 **Q. Did she not massively hemorrhage?**

18 A. Before surgery, yes.

19 And as the note from Dr. Duclas notes,
20 that she was resuscitated fully, was oxygenating
21 fully, was cognating and making movements
22 postoperatively. That although she did have a
23 metabolic acidosis, she appeared to be
24 postoperatively clinically stable until the very
25 acute event happened where she had a tremendous

1 change in status around 3 o'clock in the morning in
2 the ICU.

3 Q. Right. We'll get to that a little at a
4 time.

5 When she got to the operating
6 room -- Strike that.

7 Let's start off before that.

8 When were you --

9 You delivered the child at 8:03, I think,
10 p.m. on the night of the 26th of July, 2017.

11 And when were you notified that she was --

12 When did you notice that she was bleeding
13 afterward?

14 A. I noticed as I was repairing her cervical
15 lacerations and her mediolateral -- mediolateral
16 laceration that episodically, not continuously, she
17 would have these spurts of blood.

18 Q. Gushes as you called them?

19 A. Excuse me?

20 Q. You called them gushes.

21 A. Gushes. They were like periodic gushes,
22 that subsequently was followed by intermittent
23 crescendo, de-crescendoing uterine atony.

24 I remained at her bedside the entire time
25 until she went to the operating room.

1 **Q. Okay. Where was the massive bleeding**
2 **coming from prior to surgery?**

3 A. A segment of the lower -- a portion of the
4 lower uterine segment would be my best guess,
5 because you could actually see what appeared to be a
6 little fountain --

7 **Q. And what --**

8 A. -- when the uterus was in a certain
9 position.

10 **Q. And what would cause that?**

11 A. This patient started to push the baby out
12 before she was completely dilated.

13 **Q. She was told to, was she?**

14 A. No. She had involuntary --

15 She was told just the opposite. She was
16 told by -- her first name is Linda, I'm trying to
17 remember her last name -- she was told by the nurse
18 to hold on and not push before she was completely
19 dilated.

20 And then she involuntarily pushed, which
21 is sometimes -- it sometimes happens, because, you
22 know, you get the pressure, the rectal pressure that
23 is similar to the urge to need to defecate.

24 And I believe that was a cause or a
25 contributor to her vaginal bleeding.

1 In fact, Linda, the day nurse, was so
2 concerned, that we ordered an ultrasound to make
3 sure that although this patient at one time was
4 thought to have a low lying placenta, that the
5 placenta might have been the source of bleeding
6 while she was still pregnant with the baby inside.

7 But that ultrasound showed that the
8 placenta was posterior. So that the increased
9 amount of vaginal bleeding that came on acutely was
10 not related to the placenta whatsoever nor was it
11 related to the artificial rupture of membranes,
12 which I performed, because -- I only inserted the
13 amnihook far enough to reach the fetal head. It
14 never went into the body or the lower uterine
15 segment of the uterus. It went in very, very -- you
16 know, less than a maybe a half a centimeter past the
17 cervix.

18 **Q. Where did the lacerations to the cervix**
19 **come from?**

20 A. The mother pushing the baby out through an
21 incompletely dilated cervix.

22 **Q. Okay. So it wasn't --**
23 **So did she start to bleed prior to**
24 **delivery?**

25 A. She had some bleeding that was prior to

1 delivery related to when she was involuntarily --

2 I'm going to say involuntarily pushing, to give her
3 the benefit of the thought.

4 Either she intended to push, when being
5 instructed not to, or involuntarily pushed, which I
6 believe -- I tend to believe is more common.

7 **Q. Is there a note to that affect that you've**
8 **read?**

9 A. No. No.

10 **Q. It's something you remember?**

11 A. Yes. I remember --

12 **Q. There's not a single nursing note that**
13 **says that this lady was pushing involuntarily or**
14 **voluntarily prior to the time she was instructed to**
15 **push, is there?**

16 A. And that's why we're doing a deposition
17 today, so that I can fill in the blanks.

18 I certainly don't expect a nurse to spend
19 every minute --

20 You know, maybe we could start video
21 recording patients the whole time they're in labor.

22 **Q. We don't need to do that, Doctor, because**
23 **we have an almost minute by minute medical**
24 **electronic record, the complete episode record,**
25 **before she was delivered almost minute by minute**

1 that the nurses note maternal heart rate,
2 contractions, all these other things, including when
3 you were there trying to rupture the membranes with
4 an amnihook, including when she did start to push
5 pursuant to the nurse's instruction, after she was
6 crowning. That's all in the record. And there's --
7 you know, there are literally hundreds of
8 documentations in the record by the nurse.

9 There's not a single one that says that
10 this lady was pushing when she wasn't supposed to be
11 pushing; correct?

12 A. My testimony stands.

13 Q. That's not what I asked.

14 Am I correct, sir, that there's not -- out
15 of the hundreds of nursing notes notations on this
16 record there's not a single one that says that she
17 was pushing before she was told to push; correct?

18 A. The documentation is limited in terms of
19 the capacity of the nurse to meet all of her
20 obligations.

21 Q. Yes, Doctor. You've done this a lot as an
22 expert witness. We have your depositions. And I
23 know how it works with expert witnesses trying not
24 to directly answer a question.

25 I'm going to ask you to do that.

1 Is there a documentation -- out of the
2 hundreds of documentations by the nurse prior to
3 birth is there any documentation by the nurse that
4 this lady was pushing involuntarily or voluntarily
5 when she wasn't supposed to, yes or no?

6 A. I did not see in the voluminous nursing
7 notes that that was documented, no.

8 Q. Now, it was noted at 8 o'clock, 8:01, the
9 night of delivery, just before the baby delivered,
10 that the patient was encouraged to push with
11 contractions, pushing effectively and decent noted.

12 That's the first time in the record it's
13 noted -- and the only time, in fact, because the
14 baby was born a couple minutes later, the only time
15 in the nursing notes that anyone says this patient
16 was pushing; correct?

17 A. That was a different nurse and a different
18 time. But yes, that's correct.

19 Q. In your notes that you wrote pre and
20 postop -- pre and post-delivery did you write
21 anywhere that this patient was pushing
22 inappropriately or involuntarily at any time prior
23 to when she was ordered to push?

24 A. No.

25 Q. Did you write that there was any bleed

1 coming from this lady at any time pre-delivery?

2 A. No.

3 Q. Did you write that the cervical
4 lacerations -- of which there were several; correct?

5 A. Yes.

6 Q. -- were caused by the lady pushing?

7 A. No.

8 Q. Did you write, sir, that --
9 Well, leave it at that.

10 Why didn't you write in the record, since
11 you were faced with these complications that
12 occurred, and you had a number of documentations
13 that you made, what you told us today, that this
14 lady was pushing inappropriately or involuntarily
15 and that that was showing bleeding which led to
16 massive uterine hemorrhage after birth and that
17 caused several cervical tears; why is that not in
18 the record?

19 A. Because in the event that I needed to
20 explain the why, I could have an oral examination,
21 as we're doing today, and explain what I believe was
22 the cause of their uterine bleeding.

23 Q. Wouldn't you want that in the record for
24 that reason, in case someone had to explain why this
25 lady died, that you would have in the record a

1 documentation made by you or a nurse that this lady
2 had pushed when she shouldn't have and caused
3 cervical lacerations and uterine -- a fountain, as
4 you put it, of bleeding? Wouldn't you want that in
5 the record so that you could say at a deposition
6 like this, well, see, I put it right in the record
7 at the time?

8 A. It's simply not possible to record every
9 event in anticipation of every subsequent
10 complication.

11 Q. You know, I've heard that --

12 A. It's not possible for -- to record the
13 totality of factors that may contribute to an
14 adverse outcome.

15 Q. And I've heard that mentioned tens of
16 thousands of times over the last 39 years that I've
17 been doing this by experts.

18 But when you're talking about the cause of
19 the bleed which led you to have to take her to
20 surgery, we're not talking about documenting every
21 single movement you made, but when we're talking
22 about the cause of the lady's massively bleeding,
23 don't you think that if that happened the way you
24 said it would that you would make a documentation of
25 that in the medical record?

1 A. If I had the ability to predict the future
2 in advance, I certainly would have.

3 In this particular patient's case, the
4 sequence of events that led ultimately to her having
5 to have emergency surgery were documented.

6 Whether the cause was she pushed
7 involuntarily and tore her self, the end result
8 would have been the same, she would have
9 eventually -- she failed medications, she
10 wouldn't -- she had to have a hysterectomy to try to
11 save her life from her own medical condition.

12 **Q. Okay.**

13 A. Her uterine atony was related to her blood
14 loss related to her involuntarily pushing and
15 tearing herself in the middle.

16 **Q. You're saying that even before she**
17 **delivered she had substantial blood loss?**

18 A. That's not what I'm saying at all.

19 **Q. Are you saying that?**

20 A. I didn't say that at all.

21 **Q. I'm asking you, are you saying that now?**

22 A. I'm not saying that at all.

23 **Q. Okay.**

24 A. I'm saying that over time that laceration
25 that she internally caused by involuntarily pushing

1 led to a cascade of events that led to her having to
2 have an emergency hysterectomy.

3 Q. Okay. So this laceration -- this pushing
4 that doesn't exist anywhere in the record before or
5 after birth, this pushing that you say she was doing
6 that lead to lacerations, where is the evidence in
7 the record of any maternal bleeding prior to the
8 baby's birth?

9 A. It's not recorded.

10 Q. Why not?

11 A. It just wasn't.

12 Q. Should it be by the nurses who are doing
13 these minute by minutes notes?

14 The mother is bleeding vaginally.
15 Shouldn't that be something you're aware of and that
16 the nurses make a note of?

17 A. Well, again, what happened in this case,
18 as you know, there was an ultrasound that was
19 performed during the labor process because of the
20 concern of the bleeding. The indication for that
21 ultrasound didn't specifically address what it was
22 that caused the bleeding.

23 In fact, you had asked me what do you
24 think might have been the cause of the bleeding, and
25 I'm -- I gave you my answer. I think she pushed

1 prematurely involuntarily maybe.

2 **Q. The order for the ultrasound, did it say**
3 **because of maternal bleeding?**

4 A. I don't recall the exact -- what
5 Nurse Chesney wrote down as the indication.

6 **Q. If I would tell you that the nurse on a**
7 **number of occasions wrote bleeding none or zero,**
8 **would that surprise you?**

9 A. It would, because Nurse Chesney called me
10 out and asked me about the patient's placental
11 location.

12 **Q. Right.**

13 **Well, that's --**

14 A. And I explained to her it was not known to
15 be persistently low lying, although at one time it
16 was of interest.

17 Let me see if I can find the ultrasound --
18 the official ultrasound report.

19 **Q. By the way -- while you're doing that --**
20 **were you able to rupture the membranes with the**
21 **amnihook on your first attempt?**

22 A. I thought I had. But I thought the head
23 was so well applied to the cervix that no free fluid
24 was released.

25 **Q. Nurse Chesney documented at 8:51 in the**

1 morning on the 25th that -- sorry.

2 At 10:26 Nurse Chesney noted, "Dr. Lopez
3 at bedside. Examines patient. Attempts to rupture,
4 unable to. Blood clots present."

5 A. And that was the basis for the concern
6 that the patient had been pushing and thus
7 internally tearing a portion of the lower uterine
8 segment.

9 Q. If she was tearing the lower portion of
10 the uterine segment by pushing, wouldn't that lead
11 you to suggest a Cesarean section?

12 A. No.

13 Q. So you wouldn't wind up with a massive
14 bleed?

15 A. No.

16 The quantity of bleeding that was noted
17 did not appear to be massive at that time.

18 Q. How was she bleeding from the uterus --

19 A. Inside.

20 Q. Excuse me.

21 How was she bleeding from the uterus --

22 If the bag of waters had not ruptured yet,
23 how did you know she was bleeding inside the uterus?

24 A. The blood was coming out.

25 Q. Coming out from where?

1 A. The vagina.

2 Q. But she --

3 A. Around the cervix.

4 It's a liquid.

5 Q. Yes, I know what --

6 A. It comes around the cervix as a liquid and
7 forms a clot and then come out through the vagina.

8 Q. And when you tried to rupture the
9 membranes and you couldn't do so, you made no note
10 of that, of any bleed, did you?

11 A. No.

12 Q. I'm not talking about a clot. I'm talking
13 about a bleed.

14 A. No, I did not.

15 Q. And afterwards, when you did your
16 post-delivery note and your postop note after the
17 hysterectomy, you never mentioned anything about
18 that, did you?

19 A. No.

20 But it is noted in the pathology report
21 where they found on the cervix -- I should say the
22 lower uterine segment, an increase in the
23 vascularity proximal to the area of excision. And
24 that's what leads me to the conclusion that this was
25 the basis for which this patient had a bleed that

1 was probably caused by injury to the internal part
2 of the uterus, most likely from improper pushing
3 prior to being completely dilated.

4 Q. You were going to look at the ultrasound
5 report, sir. I'll let you do that.

6 A. Here we go.

7 Well, it's --

8 Q. Okay.

9 A. It seems to be -- it seems to say evaluate
10 placental position and fetal position. This was on
11 page 1049. It does not mention the bleeding.

12 Q. No, it doesn't.

13 A. But the indication was, in fact, for
14 bleeding.

15 Q. Doctor, when you place an order, if you
16 felt that the indication for the ultrasound was
17 bleeding, that's what you would order, you would say
18 indication for procedure, bleeding, suspected
19 bleeding; right?

20 A. It depends. Because of the electronic
21 medical record, sometimes the drop down menu
22 items -- if you're going to get an ultrasound, many
23 times what you pick doesn't necessarily much matter,
24 because the procedure for the ultrasound is going to
25 be the same whether it's done for bleeding or fetal

1 position or placental position.

2 Q. But you had the ability --

3 A. I am not sure vaginal bleeding was an
4 option.

5 Q. Really?

6 There's no "other" on the take down thing?

7 A. I don't recall.

8 Q. No?

9 But you put nowhere when you ordered
10 this -- it was not for bleeding, as it says here, it
11 was to evaluate the placental position and the fetal
12 position. Nothing about bleeding; correct?

13 A. It's not indicated in the order; correct.

14 Q. Let me read specifically. Where it says
15 ultrasound -- obstetrical ultrasound History:
16 Evaluate placental position and fetal position.

17 Nothing about bleeding; correct?

18 A. Correct.

19 Q. And in the ultrasound they saw no evidence
20 of bleeding, did they?

21 A. They don't record any evidence of
22 bleeding.

23 Q. You certainly suspect if they saw bleeding
24 that they would record that, wouldn't you?

25 A. Well, it depends on the amount of

1 bleeding, because you have to have a sufficient
2 amount of blood such that you could see bleeding.

3 Now, as I mentioned before, the bleeding
4 was actually being released through the cervix into
5 the vagina.

6 **Q. It wasn't measured, was it?**

7 A. No.

8 **Q. Why not?**

9 A. It wasn't a hemorrhage at the time. At
10 10:22 in the morning, it was -- it could have been
11 bleeding from the cervix dilating. That happens.
12 And sometimes that happens before labor comes on and
13 we call it bloody show. But it seemed heavier than
14 bloody show, but not enough to cause me concern,
15 other than to order the ultrasound.

16 I don't know if you've taken
17 Nurse Chesney's deposition yet, but --

18 **Q. Not yet.**

19 A. Excuse me?

20 **Q. Not yet.**

21 A. Then you can ask her whether or not that
22 was the indication, whether she's in agreement with
23 what I'm telling you now or not.

24 If she didn't record it, maybe you can
25 criticize her.

1 Q. Or maybe she's going to say that it wasn't
2 bleeding.

3 A. You can criticize her for not checking the
4 correct box, because the person who actually checked
5 the box was her, not me. I gave it as a verbal
6 order.

7 Q. And would you criticize her for not noting
8 in the record that the patient was bleeding?

9 A. Yes.

10 Q. And there is no notation of it, but you
11 say she was?

12 A. I saw it. Sure.

13 That's why we do depositions, is so that
14 you can get the information that isn't recorded.

15 Like I said, it would be quite --

16 Q. But there's no --

17 A. Sir, if you keep interrupting me while I
18 answering the question, we can terminate today's
19 deposition and take it up before the judge.

20 Q. If you'd answer my question directly, it
21 may be easier and quicker.

22 A. Interrupting my answer?

23 Q. Go ahead, sir. Answer whatever you want.

24 A. I'm asking you politely with respect.

25 We're still in Palm Beach County and the rules of

1 conduct apply.

2 Q. Certainly.

3 A. You have to allow me to answer my
4 question -- answer a question you pose.

5 Q. See, doctor, as an expert witness, that
6 you've done many, many, many times, I know that you
7 try to talk around an answer and you try not to give
8 a direct answer when you don't want to.

9 What I'm asking you to do today -- and I
10 will give you the chance to respond to any question
11 with a yes or no, and then you can explain it -- but
12 you are also required to give me a direct answer to
13 a direct question first. And I'm asking you to do
14 that.

15 In some of the recent answers you have not
16 done that, as I perceive it.

17 And so I'll abide by your request to allow
18 you to answer, if you abide by my request to please
19 answer my question.

20 A. You have my full cooperation.

21 Q. Okay. So the baby was delivered at
22 8:03 p.m. on the evening of the 25th, and the baby
23 was fine.

24 There was oxytocin given routinely, I
25 imagine, two minutes later; correct?

1 A. Yes.

2 Q. And at 2:09 -- 2:06 there's something
3 about alarm acknowledged.

4 Do you know what that means?

5 A. No.

6 Q. And then at -- when I said two, I meant
7 2006.

8 At 2009 or 8:09 p.m. it says Remarks:
9 Hemabate given per M.D.

10 Now, Hemabate is what?

11 A. It's a medication -- it's a prostaglandin.
12 It's used to make the uterus contract down firmer
13 after the birth of a child.

14 Q. And oxytocin does the same thing; correct?

15 A. Yes, sir.

16 Q. And the Hemabate was, in fact, given at
17 8:09.

18 And what was the indication for that in
19 this case?

20 Is that normally given or was it an
21 indication that she was already bleeding?

22 A. She's already bleeding. Bleeding more
23 than would be expected after a delivery.

24 Now, after the delivery I inspected the
25 placenta and saw that it was, in fact, intact; in

1 other words, it was not missing cotyledons or
2 portions of it. The membranes were also all there.
3 And the umbilical cord was all there.

4 Now, I did not document that. But that
5 happened immediately upon the release of the
6 placenta.

7 And we saw -- I saw that the amount of
8 bleeding was more than the usual amount, even though
9 she was receiving uterine massage and oxytocin
10 through her -- in the usual quantity through an IV
11 line, I ordered and administered Hemabate.

12 **Q. Where did you think that bleeding was**
13 **coming from?**

14 A. At that point it appeared to be coming
15 from inside the uterus.

16 **Q. And if it's inside the uterus as opposed**
17 **to the cervix --**

18 **The uterus is above the cervix; right?**

19 A. Yes.

20 **Q. Goes into the cervix?**

21 A. Correct.

22 **Q. If it's coming from the uterus, you're**
23 **attempting --**

24 **The uterus is a muscle; right?**

25 A. Yes.

1 Q. And atony means that it's not contracting
2 the way you would expect it to be?

3 A. Correct.

4 Q. So that's why you gave Hemabate and
5 oxytocin, to see if that would stop the bleeding
6 from the uterus?

7 A. In addition to uterine massage.

8 That's correct.

9 Q. Okay. Now, you also were performing at
10 8:10, a minute after the Hemabate, performing
11 cervical laceration repairs.

12 Did you note bleeding from the cervical
13 lacerations?

14 A. Not that much.

15 And that's what was one of the causes of
16 concern.

17 As I was doing the cervical laceration
18 repair, I requested something called mini laparotomy
19 packs. And what those are -- it's gauze, surgical
20 gauze about, I'm going to say, an inch and a half by
21 about 6" long, with a blue tag at the end of it. So
22 when I concluded the repairs of multiple lacerations
23 of the cervix.

24 And, again, those lacerations of the
25 cervix are common when a patient has pushed before

1 complete dilation of the cervix; in other words, the
2 cervix isn't completely gone from the baby's head.
3 If you push, the forces can tear the cervix.

4 And I actually tamponaded the lower
5 uterine segment with a mini laparotomy pad, and
6 the -- there was no bleeding from outside of the
7 mini laparotomy packed tampon. And the mini
8 laparotomy tampon became saturated with blood.

9 In fact, I used several of him serially.

10 **Q. Twenty-five, actually.**

11 A. I had them weighed to get an estimate of
12 how much blood was coming through -- from the inside
13 of the uterus, not the outside of the uterus.

14 **Q. If she was bleeding from the uterus --**
15 **Well, strike that.**

16 If she was bleeding from the cervix as a
17 result of this undocumented pushing that you say
18 happened, that bleeding would have been taking place
19 throughout the remainder of her pregnancy, before
20 the baby was born, from the time she started pushing
21 to the time that you delivered the baby and even
22 thereafter?

23 A. I'm not sure I understand your question,
24 sir.

25 **Q. How did the baby -- how did the pushing**

1 lacerate -- the word laceration seems to be --

2 Isn't that a cut, a laceration?

3 A. There's several different ways that it can
4 happen.

5 Q. As opposed to a rupture, in other words.

6 A. Yes.

7 We can argue it one way or the other
8 whether it was a cut, a laceration or a tear.

9 If we were to say that as the head comes
10 through the cervix -- the cervix generally, which is
11 kind of rubbery, it's muscle and fibrous connective
12 tissue, will expand to a point. If the pressure
13 exceeds the strength of that muscle connective
14 tissue portion of the cervix, if -- you'll get --
15 you'll get a tear or a laceration.

16 And a laceration is a nonsurgical cut,
17 tear, rip that can cause bleeding.

18 Q. At what stage of the head decent --

19 What actually causes the laceration, is
20 what I'm getting at?

21 If the head is not yet coming through the
22 civics, how does this laceration occur?

23 A. It happens because the elasticity of the
24 cervix --

25 It's like a rubber band. If you go beyond

1 a certain round area of space and exceed the ability
2 of the elasticity of the rubber band, the rubber
3 band will break, rupture or tear and tear open.

4 If the patient pushes before the cervix is
5 completely off the head, then the cervix will tear.
6 It will tear because the force of -- the
7 propulsatile force of the baby's head coming through
8 the cervix, not completely dilated, is like a force
9 greater than that tensile strength, the strength of
10 a rubber band to stay intact, and a laceration or a
11 tear will occur.

12 **Q. But --**

13 A. In that regard --

14 Let me also say this, please. Blood
15 vessels that form on the inside of the lower uterine
16 segment, like were noted on pathology report of the
17 portion of the lower uterine segment that was
18 removed, notes that some of those blood vessels were
19 large and dilated. And that would be higher up than
20 the cervix. Which, as you know, I left the cervix
21 in. I didn't remove the cervix.

22 **Q. How do you know that?**

23 A. Because I knew, having examined the
24 patient with my own eyes, even though I didn't
25 record it, that there was no bleeding coming from

1 the cervical lacerations. That was not the source
2 of this woman's hemorrhage. It was internal to that
3 and superior to that, by a process of deduction.

4 When I put the mini laparotomy tampons and
5 there was no bleeding from where the suturing up had
6 occurred, that wasn't the cause of a postpartum
7 bleed. It had to be higher up.

8 And that's why that technique is used.
9 You tamponade the cervix. And if the bleeding is
10 coming north of the cervix, it's not the cervix
11 that's causing the postpartum bleed and relieving --

12 Q. Why --

13 A. Excuse me. Let me finish.

14 Q. Well, it's going on a little bit, Doctor.
15 More than I asked you.

16 A. I apologize for that, sir.

17 Go ahead.

18 May I ask a question?

19 Could I take a one minute break to get a
20 little more coffee?

21 Q. Sure.

22 (Whereupon, a short break was taken.)

23 BY MR. COHEN:

24 Q. Now, Doctor, according to the medical
25 record, while you were attempting to repair the

1 cervical lacerations, they -- there was another
2 30 units of oxytocin given at 2020 or 8:20, and
3 there was another dose given at what looks -- I
4 don't know if that's the same note or not, so I'll
5 leave that alone. But it does say at 8:30, "M.D.
6 remains at bedside. Performed cervical laceration
7 repairs."

8 How many lacerations were there of the
9 cervix, do you know?

10 A. I believe in total there were three.

11 And that's the other thing that kind of
12 led me to believe that she had pushed before the
13 cervix was completely dilated, because the location
14 of these lacerations -- one would have been at about
15 10 o'clock, the other one would have been on the
16 face of a clock, I'm going say, probably around
17 2 o'clock, and then the other one towards the bottom
18 would have been around say 7 o'clock.

19 And that stellate pattern is somewhat
20 typical of when a head goes through a cervix that's
21 not completely dilated. It tears kind of in
22 quadrants.

23 But in this case there were only three.
24 And they were repaired to the point where there was
25 no blood coming after, you know, I tamponaded the

1 end -- the uterine entrance.

2 Q. You wrote a progress note. It says
3 here -- it's timed at 8:10 into the postpartum note.

4 I'm just going to hand it to you.

5 A. Thank you.

6 Q. Can you read that note to us.

7 A. "Postpartum hemorrhage treated with IV
8 Pitocin, Hemabate IM times one, Cytotec rectally
9 1000 micrograms. Massage. Second IV line placed.
10 Anesthesia, nursing supervisor called. Recommend
11 hysterectomy."

12 Q. Okay. So there's no mention in that note
13 that she had any pre-delivery bleeding or that she
14 had pushed in a way that caused lacerations or
15 hemorrhage, is there?

16 A. No.

17 Q. And you certainly could have put that in
18 there if you chose to?

19 A. If I had the ability to know in the future
20 that litigation would ensue, certainly.

21 Q. No, sir.

22 If that's what had happened, wouldn't you
23 have written in your note something that important,
24 that she had been pushing against somebody's rules
25 and that she had lacerated her cervix and possibly

1 uterine bleeding because of pushing?

2 Wouldn't you make a note of that?

3 This is not a drop down menu. This a
4 handwritten note.

5 A. Right.

6 And the answer to that is, again, if I had
7 the ability to have foresight, yes, in this case.

8 If I did that -- if I wrote that in every
9 single case that it happened, then it maybe would
10 have made me a better documenter.

11 But as a trained surgeon, as a trained
12 gynecologic surgeon, my notes have always tended to
13 be brief and maybe not as comprehensive as nurse's
14 notes.

15 Q. And the nurse's notes, as we said, don't
16 mention any of that, either. The very comprehensive
17 nursing notes don't mention anything about bleeding
18 in any way prior to the delivery of the baby;
19 correct?

20 A. That's right.

21 Q. Okay. The charge nurse, Miss Shanken, was
22 called to the bedside at 8:30 for additional
23 assistance.

24 And at 8:45 p.m. it says, "The patient
25 remains moderate lochia flow, fundal massage

1 performed by M.D. Large gush blood noted with
2 clots. Fundus firm after massage."

3 Tell me what that means.

4 A. What that means was, what was happening
5 was, there was some periods of time where the amount
6 of bleeding diminished as if it was going to stop or
7 become what we would consider an appropriate amount
8 or an acceptable amount of bleeding, and then it
9 would crescendo, meaning the volume would increase
10 acutely. And -- with fundal rubbing the whole time,
11 okay, after all the lacerations repaired, the
12 cervical as well as the vaginal laceration was
13 repaired, there would be a crescendoing, meaning a
14 spike in bleeding and then it would stop, it would
15 slow down. So it was like a spasming blood vessel
16 on the inside of the uterus was the cause.

17 And that's the thought process that I had,
18 that this is the type of bleeding that since it's
19 failed Pitocin, it's failed more Pitocin, it's
20 failed methargen -- I'm sorry -- Hemabate, and it's
21 failed Cytotec, which is, you know, another
22 medicine, so essentially three medications, physical
23 massage, surgical repair of what is visible, what I
24 can see. What I can't see is what is going on
25 inside the uterus. But what I can see is the

1 quantity of blood. And, again, it fits a pattern of
2 crescendoing, then de-crescendoing, crescendoing,
3 de-crescendoing. There were times when we thought
4 we had this thing stopped. The uterus had
5 contracted down like it was supposed to.

6 Q. Okay.

7 A. But then we recognized that that wasn't
8 the case at all. Her vital signed changed. We
9 ordered blood testing and blood work; meaning, CBC.
10 And I ordered, in addition, two units of packed red
11 blood cells. At the same time I asked for the
12 nursing supervisor and other parts of the supporting
13 team, including at one time a rapid response team to
14 come to the room, the anesthesiologist to come to
15 the room, because it appeared that all of our
16 conservative measures of stopping this postpartum
17 bleed were failing and we were going to have to go
18 to the next level.

19 Q. At 8:45 there's the note I just read from
20 the nurse about the large gush of blood noted,
21 fundal -- fundus firm after massage.

22 Also at 8:45 it says the maternal blood
23 pressure was now 95/58.

24 That was a drop from what it had earlier
25 been; correct?

1 A. Yes.

2 Q. Did that give you evidence that the
3 patient was losing blood?

4 A. Yes.

5 And that's why we asked the nursing
6 supervisor to get an operating room ready.

7 Q. And that was at 8:45.

8 And then her maternal heartbeat was at
9 128.

10 That's high, isn't it?

11 A. Yes.

12 It's gone up. It went up. It's
13 accelerating.

14 Q. Trying to compensate for the loss of blood
15 pressure?

16 A. Yes, sir.

17 But by that time blood had been ordered
18 from the blood bank.

19 Q. Now, blood wasn't given to this patient
20 until in surgery later on; correct?

21 A. That's right.

22 There was definitively -- you know, if I
23 had a couple of criticisms, my first criticism is
24 that the blood banking was exceptionally slow, as
25 was getting the results of her blood work that was

1 ordered in an emergency situation. Her blood work
2 was ordered stat as was the blood that was supposed
3 to be getting ready to be crossed. It was not
4 given -- it was not available to be given even after
5 the anesthesiologist came, Dr. Duclas, and ordered
6 four more units of untyped uncrossed blood. Blood
7 did not come for a while. And for that I fault
8 Good Sam and their blood banking unit.

9 Q. All right.

10 A. And their laboratory.

11 Q. If it had come when you ordered it on the
12 time basis you would have expected it, you would
13 have started it earlier?

14 A. Absolutely. We would have given the blood
15 immediately. Yes.

16 Because once she became tachycardic, we
17 all knew she needed blood, when I say all, the nurse
18 and I, the nursing supervisor.

19 In fact, we spoke fairly curtly about we
20 need to get blood bank -- somebody call blood bank.

21 My impression, and I can't -- again, this
22 investigation is not done by a long stretch -- maybe
23 they were shorthand.

24 The phlebotomist took awhile to get down
25 to draw the blood to begin with. It took a while to

1 get the blood to begin --

2 We were already doing surgery by the time
3 the blood arrived.

4 And that's wrong. That blood should
5 have -- this is a special care unit. Blood should
6 have been available much more quickly than it was.

7 **Q. Do you think if it had been that this lady**
8 **had a better probability of surviving?**

9 A. Yes, sir. Depending on what you wish to
10 believe how much of the --

11 You know, the pathologist wrote a report.
12 Like I said, I have some concerns over.

13 And, again, both sides get to say -- get
14 to have somebody look at it.

15 If we were able to have gotten the blood
16 more timely, I believe she would be alive today.

17 **Q. Okay.**

18 A. And if we were able to have gotten blood
19 in a timely way, I truly believe Miss Lopez Castillo
20 would be alive today.

21 **Q. Okay.**

22 A. Castillo-Lopez. I'm sorry.

23 **Q. That's okay.**

24 So at 8:57 -- now, this is about 55, 54
25 minutes after the baby was delivered -- her maternal

1 blood pressure, the mom's blood pressure, was 66/45.

2 So it had dropped substantially; correct?

3 A. Yes.

4 Q. And her heart rate had risen to 136, it
5 looks like, at the same time; meaning, that her
6 heart was beating faster to try to compensate for
7 lack of blood pressure because the blood volume was
8 dropping?

9 A. Correct.

10 Q. And when somebody's blood pressure is down
11 that low and their heart rate is speeding up to
12 compensate for it and there's a loss of blood
13 volume --

14 There was a substantial loss of blood
15 volume at that point; correct?

16 A. Yes.

17 Q. Enough to effect her vital signs in this
18 way?

19 A. Correct.

20 Q. Okay. Do these numbers indicate that
21 she's going into shock?

22 A. Yes.

23 Q. Okay. Would you agree that with
24 reasonable probability at this point she was in
25 shock?

1 A. Yes.

2 Q. Secondary to blood loss?

3 A. Correct.

4 Q. And then at 2100 hours, which is
5 9 o'clock, it has a quantitative blood loss obtained
6 through 20 soaked mini pads 526 grams.

7 What does that mean?

8 A. Well, that was documentation by the weight
9 of the laparotomy packs. In other words, they took
10 all the ones that had blood in it, and then they
11 weighed one that didn't have blood on it, so that we
12 knew that beyond any doubt that we were dealing with
13 a postpartum hemorrhage by every definition in the
14 book.

15 Q. Okay.

16 A. Okay. We already knew that clinically.
17 That was a documentary -- this is one of
18 those things to make you happy that you didn't
19 document, you didn't say -- you said this, but you
20 didn't write it down. Now, we wrote it down.

21 We already knew what the problem was.

22 The problem was --

23 We already ordered blood.

24 The problem was, the blood bank wasn't
25 bringing in a way that we were going to be able to

1 resuscitate this woman before we had to go back to
2 the OR.

3 **Q. And she was continuously bleeding at this**
4 **time?**

5 A. Correct.

6 But we were massaging. I was at the
7 bedside, I was there. The nurse was there.

8 **Q. But the Hemabate and the oxytocin were not**
9 **stopping the bleeding?**

10 A. Correct.

11 And there's time limits as to how often
12 you can give them. You know, the Hemabate, I think,
13 like 20, 30 minutes is typical. The Pitocin was
14 going -- the lower dose of Pitocin was what she
15 started out with. Then we added more Pitocin to
16 give her a higher dose.

17 This was not -- her uterus was also in
18 shock. It wasn't just the mother, it was her
19 uterus.

20 And what I mean by shock is, it's not
21 responding in a typical manner because it's blood
22 deprived.

23 **Q. So it's completely atonic?**

24 A. I wouldn't say 100 percent atonic. But it
25 was more atonic than it wasn't.

1 Sometimes it would respond just a tiny
2 bit; again, crescendoing, de-crescendoing, in terms
3 of the amount of blood that would pop out. The
4 uterus would have moments where it was firming a
5 little bit, but it wasn't stopping. We knew she was
6 going to be having to go to the OR.

7 **Q. And that was my next question.**

8 **By 8:45, when you were -- you know, the**
9 **large gush of blood was happening and the vital**
10 **signs were dropping, had you already made the**
11 **decision that this lady needed to go back to -- to**
12 **go to surgery?**

13 A. Yes.

14 **Q. At about 8:45?**

15 A. Correct.

16 Actually, one other thing happened that
17 wasn't documented, I asked for something called the
18 postpartum hemorrhage cart.

19 The postpartum hemorrhage cart is a --
20 it's like a red Craftsman tool cart that usually
21 contains things like a -- something called the Bakri
22 balloon, which is like a tube that you can fill with
23 saline to put inside the uterus to cause mechanical
24 distention. It also usually will contain
25 medications such as methargen, which would have had

1 to be requested from either the Pyxis or downstairs
2 from the pharmacy. It would have the ability to
3 have a large quantity of not the mini laparotomy
4 packs but the large packs, in case I wanted to pack
5 the uterus with laparotomy packs.

6 These are all mechanical ways of stopping
7 internal uterine bleeding.

8 They didn't have one. I asked for one.
9 It didn't exist.

10 Q. Okay. Again, you already said, I think,
11 that that was not noted anywhere in the record?

12 A. It's not noted.

13 Q. But that's what you remember?

14 A. That's correct.

15 Q. And that would not be within the standard
16 of care for the hospital to not have that available,
17 would it?

18 A. Among other things.

19 Yes. That's correct.

20 Q. The order date --

21 Have you looked to see when the actual
22 blood was ordered for the first time?

23 First -- let me ask first, did you order
24 the blood or did Dr. Duclas or somebody else order
25 the blood?

1 A. I was the first person to order blood.

2 Q. Okay.

3 A. I was also the person that asked and
4 called for Dr. Duclas to respond.

5 Q. Okay.

6 A. Who was the anesthesiologist who was on
7 call.

8 I knew that because the patient during the
9 time we did cervical repairs had a active epidural
10 going.

11 Q. Right.

12 Do you know, sir, when the first request
13 for a blood -- for blood products to come up to this
14 lady's bedside was?

15 A. I don't recall the time. It is recorded
16 in the blood requisition slip.

17 Q. Right.

18 And the first time I have is 2122, which
19 would be 9:22, which is over an hour after she
20 started bleeding or was noted that she started
21 bleeding.

22 You think it was earlier than that?

23 A. Of course it was, for the following
24 reasons: They use an electronic medical ordering
25 record at Good Sam, so in order for the order to go

1 to the blood bank, in today's world a nurse has to
2 go in front of a computer, log in, put in her log,
3 go through the panels until -- what I mean by panels
4 is, each screen shot, you've got to go to the blood
5 banking screen shot, you would have to check packed
6 red blood cells, have to type in probably
7 everything .

8 -- if you would tell me what page you saw
9 that, the time on it, I'll tell you everything she
10 has to type in, which is more than a few things.

11 **Q. On the --**

12 **A. It's not that relevant.**

13 What I'm going to tell you is, they have
14 to fill in a series of pages -- not pages, but lines
15 on that screen shot before the order gets fired off
16 electronically to the lab.

17 **Q. Okay. Is there something --**

18 **A. To the blood bank. I'm sorry.**

19 **Q. Was there something that was called a**
20 **massive hemorrhage protocol at Good Sam at the time?**

21 **A. Yes. I believe it existed.**

22 **Q. Okay. And it's something that you were**
23 **aware of at the time?**

24 **A. I was.**

25 **Q. Did you institute that protocol?**

1 A. No. And I'll tell you why; when
2 Dr. Duclas came into the room, he ordered the
3 massive blood transfusion protocol.

4 And, in addition --

5 I've known Dr. Duclas. He's an excellent
6 anesthesiologist, also an intensivist of sorts, has
7 training in taking care of very sick post-hemorrhage
8 patients.

9 He asked to institute the massive
10 transfusion protocol.

11 **Q. Is that noted anywhere in the record, that**
12 **anybody instituted the massive transfusion protocol?**

13 A. I never saw it, no.

14 Now, this is --

15 **Q. Tell us what it is.**

16 A. Well, there's a number of -- it is an
17 order device whereby the order set, which would
18 consist of -- if you order four units, you get four
19 plus two units of blood. You get whatever amount of
20 blood you ordered plus more on an ongoing basis.

21 What it is in a global sense is, it sends
22 the signal to the blood bank all hands on deck to
23 get lots of blood available. Okay. There's a
24 bleeding emergency in progress.

25 It usually will include certain clotting

1 factors, it will automatically include platelets, it
2 will automatically include red blood cells, it will
3 automatically -- like I said, it would automatically
4 include fresh frozen plasma, platelets, red blood
5 cells, and I think Factor VII, in most hospitals.

6 I have seen it implemented while I was
7 walking through the operating room hallways when a
8 vascular case would be going on. A nurse would run
9 out of the room and go "we need to implement the
10 massive bleeding protocol."

11 Q. Okay.

12 A. Okay. Now, unfortunately, another
13 criticism I kind of have of the hospital is, they
14 never did the periodic drills for postpartum
15 hemorrhage ever. And I've been there 30 years until
16 I wasn't there. And then I think there was a period
17 of time when they closed OB that I wasn't there as
18 well.

19 So I'm not exactly sure that the nurses on
20 L and D understood what he was talking about,
21 because it's not something that's commonly ordered
22 on L and D.

23 I'm sure everyone understood, he said four
24 units of packed -- four units of cells unpacked
25 uncrossed stat. And that's the second order you'll

1 see in the blood bank sequence.

2 And again, to get even to that page
3 involves a nurse to log in, type in, there may be
4 three or four screen shots that have to be completed
5 accurately or the order doesn't fire.

6 Q. So standard of care would have required
7 that somebody, whether it was you or Dr. Duclas,
8 order the -- institute the massive hemorrhage
9 protocol?

10 A. Right.

11 Massive transfusion is what we call it.

12 Q. Which is what this patient was needing?

13 A. Correct.

14 Q. What was needed for this patient. Excuse
15 me.

16 A. Yes.

17 Q. And one of the things that you mentioned
18 correctly, I believe, in the protocol is for
19 platelets are ordered as well as packed red blood
20 cells and other things, platelets get ordered?

21 A. Correct.

22 Q. Did this lady ever receive platelets?

23 A. No.

24 Q. Why not?

25 A. Well, I'm going to conjecture that the

1 reason why not may have been, when Dr. Duclas asked
2 for the massive transfusion protocol, I believe he
3 was under the assumption that, number one, it
4 existed, number two, that platelets were going to be
5 coming in the ratio that is generally used,
6 platelets, fresh frozen plasma and packed red blood
7 cells.

8 When you mix those three things in a
9 cocktail, that's what whole blood is. Whole blood
10 has red blood cells, fresh frozen plasma and
11 platelets.

12 **Q. Right.**

13 A. That's why -- you know, it's like
14 splitters and groupers. Okay. Splitters is when
15 you would order just platelets, just fresh frozen
16 plasma, just red blood cells.

17 What we were looking for was that whole
18 package.

19 Like a car with tires, a steering wheel, a
20 stereo, and in Florida an air conditioner. That's a
21 car. Okay.

22 He was expecting all of that to come as a
23 package, and it didn't come. It came -- what did
24 come came late, came slow.

25 He had the manpower. He had another

1 anesthesiologist that was there.

2 **Q. Dr. Brown?**

3 A. Right.

4 I mean, it's like the thing -- the element
5 that we didn't have in a timely way was the life
6 saving components of massive transfusion.

7 **Q. Okay. And as of 8:45 that's what she**
8 **needed?**

9 A. Correct.

10 **Q. Okay. And all the way to the end did she**
11 **get it?**

12 A. Never got platelets. I'm not sure that
13 she got the right amount --

14 In fact, when she went to the ICU I was
15 also surprised that she didn't get what she needed
16 even then.

17 **Q. Okay.**

18 A. And that is -- when I mean unit, I'm
19 talking about -- She was taking an MICU, medical
20 ICU.

21 **Q. And do you know whose job is it at that**
22 **point to see that she's getting the proper blood**
23 **products, including platelets and red blood cells**
24 **and even Factor VII, if necessary?**

25 MR. MIDWALL: Object to the form.

1 A. In a general way it would be the
2 intensivist in combination with Dr. Duclas and
3 perhaps Dr. Brown, the three people who have ICU
4 privileges.

5 I do not have intensive care unit
6 privileges at Good Sam. My orders would be moot.
7 I'm not sure they would take an order from me,
8 because in my credentialing package when I applied
9 for privileges at Good Sam, I do not have ICU
10 privileges. It's a whole separate package that you
11 have to fill out.

12 I have basic OB/GYN abilities. My powers
13 stop there. My knowledge base ends.

14 There are people that have much more
15 extensive knowledge in blood resuscitation than I
16 do, and two of them were there during our surgery
17 and a third one was there when she went to the ICU.

18 BY MR. COHEN:

19 Q. Okay. Did you ever come to -- did you
20 ever find out or get knowledge as to why this lady
21 never got platelets, never got the proper amount of
22 blood products that you mentioned she needed?

23 MR. MIDWALL: Form.

24 A. Let me answer it this way: I was
25 immediately shut down with a finger pointing towards

1 myself and the other OB/GYN. That's all -- I think
2 there was a political decision made by whoever to
3 circle around and to lay the responsibility -- you
4 know, to bring in the usual suspects. Since this
5 was an OB case, therefore it's an OB problem gone
6 wrong, rather than --

7 And, again, that's part of the reason why
8 when you're going to go before a review -- a serious
9 review of a mortality, it's very critical that the
10 members of the review be independent, be different
11 than the ones that are politically active within the
12 hospital, and can honestly and accurately note all
13 the things that may have caused or contributed to
14 this terrible outcome.

15 So when I started to ask, I was shut down
16 by the hospital -- by people in the hospital, in
17 terms of administrators, in terms of other people.
18 So I could not get an answer to my questions.

19 BY MR. COHEN:

20 Q. But the -- for whatever reason that you
21 couldn't get answers to, you'll agree that she did
22 not get the type of blood product replacement that
23 she needed?

24 MR. MIDWALL: Form.

25 A. She didn't get it. She didn't get it

1 timely.

2 I'm not sure that all the elements to
3 provide that level of care were even available at
4 that time; in other words, if the order -- if the
5 electronic order grouping for massive transfusion
6 policy didn't exist at that time.

7 Because, again, subsequently I was cut out
8 from being able to do my own independent
9 investigation as to why it didn't happen.

10 BY MR. COHEN:

11 **Q. Okay. What I was referring to is that we**
12 **know she never got platelets. And you said earlier**
13 **she didn't get -- you were concerned that she didn't**
14 **get enough blood after she was in the ICU. And you**
15 **don't know why. You were cut out.**

16 **But can we agree that she didn't get**
17 **sufficient replacement?**

18 A. Absolutely not. Yes, I absolutely agree
19 with that. She wasn't even close.

20 **Q. Okay.**

21 A. And those are the types of things that you
22 would expect the hospital to have had, since they
23 run an OB unit and things can -- blood can be very
24 critical not only in OB but in other areas, but
25 certainly in obstetrics.

1 And this was an example where all those
2 elements needed to be there well in advance of
3 Miss Castillo-Lopez coming there.

4 Q. Okay. Because these are things that can
5 be anticipated for many patients under different
6 circumstances?

7 A. Correct.

8 Q. Did you know that the intensive care
9 doctors that would cover the intensive care facility
10 at certain times of the day were actually by
11 tele view or tele doc, what they call Nuview in this
12 case, which means that they're someplace else and
13 they appear by computer?

14 A. I found out later. I knew --

15 Q. Okay.

16 A. Because I've had other patients that have
17 been transferred to the ICU.

18 Q. And, in fact, the doctor in this case that
19 was finally called about midnight, a little after
20 midnight, was actually in Jacksonville when he was
21 called.

22 A. I did not know he was in Jacksonville.

23 Q. Okay. We'll get to that later.

24 So we knew as of 8:45 that she needed
25 surgery and she needed various blood products that

1 she wasn't getting. And -- but she's not moved to
2 the operating room yet.

3 As of 12 -- excuse me -- as of 9:18 her
4 blood pressure now is 72/33, and then a minute later
5 it's 78/51, and her O2 -- her SPO2 is 83 percent.

6 Indicating to you that she's, again, in
7 shock and not getting proper blood volume?

8 A. Correct.

9 Q. Not getting proper blood volume.

10 Not having proper blood volume?

11 A. Correct.

12 She's having a hemorrhage in a more
13 serious stage, where now hypoxia is an issue. She
14 doesn't have enough red blood cells to carry oxygen
15 to all the vital organs, and almost certainly
16 heading into acidosis because of the lack of red
17 blood cells to carry the oxygen to the tissues of
18 her body.

19 Q. Now, according to the record that I
20 have -- that we have, the first order for a stat CBC
21 was at 9:15, which is over an hour after she was
22 noted to have been bleeding post-delivery.

23 Do you dispute that time as being the
24 first stat order for a CBC?

25 A. That would be the time that it was

1 entered.

2 The order could have come before that,
3 because, as I mentioned, the orders -- you know, in
4 the telephonic era, which is how we used to do
5 things in the old days, you would pick up the phone
6 and make a phone call.

7 Q. Right.

8 A. In the electronic medical record era you
9 have to have, in this case, a nurse be able to go to
10 an open computer, open up, put her codes and her,
11 you know, criteria -- credentials and codes in, wait
12 for the screen to come up, go to the lab ordering
13 section, pick the lab, pick the indication, and then
14 allow it to be sent out electronically.

15 Q. Okay.

16 A. And the time may have been 9:15 it was
17 entered --

18 Q. According to -- I don't mean to cut you
19 off.

20 Just so you know, according to the lab
21 sheet it says collected at 2115.

22 A. Okay. But the order would have taken a
23 period of time to put in, because now, again, you
24 have to go through multiple screens to get to the
25 blood order. And then it takes a period of time for

1 the phlebotomist, if they were adequately staffed,
2 and understanding that labor delivery unit is a
3 special care unit, it is not an operating room, it's
4 a special care unit that has the highest level of
5 priority in the hospital.

6 Q. I want to --

7 Before I read the lab results.

8 The night before there was a routine CBC
9 done which showed her hemoglobin was at 10.3 and
10 hematocrit at 32.

11 For a pregnant woman is that about right?

12 A. Common. That's common.

13 There's a mild anemia of pregnancy that is
14 almost universal. It would be rare to -- in my
15 practice to see a patient with a hematocrit higher
16 than 35. I don't think I've seen it --

17 Q. Okay.

18 A. This would be a typical --

19 And her platelets were normal.

20 Q. Right.

21 A. Which, I believe, is also typical, because
22 there's a physiologic hemodilution during pregnancy
23 where their total blood fluid level goes up about
24 40 percent in pregnancy.

25 Q. Okay. And now at 9:15 on the night of the

1 25th, again, about an hour and some minutes after
2 she started -- after it was noted she starts
3 bleeding, her red blood count 2.95, her hemoglobin
4 is 7.3, and her hematocrit is 22.7.

5 So what do those drops tell you?

6 A. That's a significant drop.

7 And as an OB, who was physically there,
8 the clinician, I know that that may not actually
9 reflect the actual level of what's going on, because
10 she had other clinical signs that indicated that her
11 blood loss was actually greater than what that lab
12 value meant.

13 And that's why the urgency to have timely
14 blood bank and blood banking was critical, because
15 even though the numbers were -- at 22 seem only
16 mildly to moderately abnormal, her clinical picture
17 was much more significantly worse than what the
18 numbers appear to indicate.

19 Q. Okay. And it had dropped from 32 to 22 in
20 the 24 hours.

21 So, as you said, that's an indication only
22 to an extent of how much blood she lost, she
23 actually probably lost more blood than that
24 reflects; correct?

25 A. That's correct, for a couple reasons. One

1 is, we increased her IV fluids. Okay. We increased
2 her Pitocin. And Pitocin would have an antidiuretic
3 affect, which would tend to allow her to retain more
4 water volume.

5 So the blood carrying capacity red blood
6 cells clinically appeared to be much lower than 22,
7 even though that's the number that was reported.

8 Q. What does that tell you about the
9 percentage of blood that she's lost?

10 How much does the normal average human
11 have liter of blood in their body, five, six?

12 A. Five to six, maybe.

13 Q. Okay.

14 A. I'm trying to remember. She wasn't a
15 particularly tall and she wasn't fat per se.

16 Q. No.

17 A. So five to six liters.

18 Q. Okay.

19 A. She may have lost maybe half of her blood
20 volume by that time, by her clinical parameters, not
21 by just the lab alone.

22 Q. It could be two to three liters?

23 A. Correct.

24 Q. Okay. So just for demonstration purposes,
25 I have some liters of red fluid here.

1 So by the time -- by 9:15 -- this is three
2 liters. So somewhere between two and three liters
3 of blood, and you only have five or six in your
4 body, this much has been lost and nothing has been
5 replaced yet; correct?

6 A. Correct.

7 Q. Okay. And, therefore, the organs of the
8 body are not going to be adequately perfused if this
9 goes on; correct?

10 A. Correct.

11 Q. And the patient's blood pressure, because
12 of that drop which causes lack of perfusion to the
13 organs of the body, and the patient's heart rate at
14 least initially is going to attempt to go higher to
15 try to compensate?

16 A. Correct.

17 Q. Okay. And there was no replacement of
18 this --

19 And she was continuing to bleed.

20 This is -- if she stayed here at 9:15 --

21 A. She hadn't stopped yet. Correct.

22 Q. -- she was still going further?

23 So by the time you took her to surgery,
24 which wasn't until 10 o'clock that the surgery
25 started, actually, a little after 10 o'clock, and

1 then she got the blood transfusions after that, how
2 much would you say she had lost by that point, since
3 none had been given?

4 A. It was certainly more than three liters.
5 It would be a guess. I couldn't --
6 I would say she was in severe shock.

7 Q. Okay. All right.

8 Okay. So at 2118, at 9:18, almost 9:19,
9 her blood pressure had now dropped to 55/27.

10 That's dangerously low, is it not?

11 A. Correct.

12 Q. Obviously shock?

13 A. Yes.

14 Q. And it stays low. 2120 -- excuse me -- a
15 few minutes later it's 54/30. There's some more
16 oxytocin given by bolus. And then there's a rapid
17 response called. According to the record, the nurse
18 noted -- Nurse Ryan Gavani noted that at 2125, 9:25,
19 rapid response was called by Nurse Hankin.

20 So according to the record, the first
21 time --

22 You said you ordered the rapid response,
23 or did Dr. Duclas?

24 A. No. I did.

25 Q. Okay. So the record indicates it wasn't

1 ordered until 20 minutes after 9:00, when we know
2 this started over an hour earlier.

3 Is that accurate?

4 A. I wasn't actually recording times and per
5 se -- I would depend on the record as recorded.

6 Q. But you told us that about 8:45 -- by
7 8:45, maybe earlier, that you had already decided to
8 take her to surgery. And we know her blood pressure
9 was already dropping and other things by 8:45 and
10 then it continued to get worse.

11 A. Correct.

12 Q. Why would you not --

13 If that's accurate, why would you not have
14 called the rapid response prior to 9:25?

15 A. I had the false expectation that blood was
16 going to arrive.

17 Q. Okay.

18 A. I had every expectation that blood
19 products would be there.

20 Q. All right. It's also recorded here at
21 9:25 that anesthesia was notified of need to come
22 for patient vital signs and come to assess patient.

23 So, again, that's, you know, an hour and
24 15 minutes or so after she was noticed to be
25 bleeding heavily, and 40 minutes after you made --

1 at least made the decision to go to surgery
2 according to the nursing note anesthesia was first
3 being called. Is that -- can you --

4 A. That's --

5 Q. Can you say that that's not correct one
6 way or the other?

7 A. It seems delayed. Correct.

8 Q. But it wasn't until anesthesia got there
9 that you said that Dr. Duclas -- I guess --

10 A. Duclas.

11 Q. Then you say instituted the massive
12 hemorrhage protocol, although it was never
13 accomplished?

14 A. I heard him order it. He ordered four
15 units of packed -- four units of packed uncrossed
16 untyped cells.

17 The first units I had ordered maybe a half
18 an hour earlier hadn't arrived. But the expectation
19 was that it was coming.

20 Q. Okay. At 9:30 the nursing supervisor and
21 rapid response team were at the bedside, according
22 to this. They were called at 9:25 and they were at
23 bedside at 9:30, according to the nursing notes.

24 So it indicates that --

25 Who was part of that rapid response team

1 **in this case?**

2 A. Usually it's an intensivist -- I'm
3 sorry -- a hospitalist who's in the hospital. If
4 the hospitalist is tied up, they would send the
5 mid level of the hospitalist service to come and
6 evaluate the circumstances.

7 They came into the room, they saw that
8 there was a physician present, they may have written
9 a note, and then I believe they left.

10 **Q. Okay.**

11 A. Because they probably also recognized that
12 what was needed was blood and blood products. They
13 can't create blood or blood products. They were not
14 going to be able to advance the care of this
15 patient.

16 **Q. Okay. Were there any pressor agents given**
17 **up to this point to try to raise the blood pressure?**

18 A. No.

19 **Q. And the reason for that?**

20 A. I don't have pressor privileges.

21 **Q. A pressor, just so the record is clear, is**
22 **medications that are used to increase the blood**
23 **pressure in the face of shock and loss of blood;**
24 **correct?**

25 A. Correct.

1 Q. And what you're telling me is that even if
2 you had wanted to order pressors, you were not
3 allowed to pursuant to your privilege -- the
4 privileges you had at that hospital?

5 A. Correct.

6 Furthermore, I don't believe the nurses on
7 labor and delivery are trained in the use of
8 Levophed or epinephrine or any of the other pressors
9 that are used.

10 Q. Then why not call immediately back, you
11 know, an hour earlier, somebody like an
12 anesthesiologist who would have privileges; correct?

13 A. Yes.

14 Q. Why not call somebody like that to come,
15 or an intensivist or whatever you needed to give
16 pressor agents?

17 Did you not think they were necessary?

18 A. I thought blood was going to be there
19 sooner than it came. I can only imagine if I had
20 asked --

21 Well, first off, the intensivist is in
22 Jacksonville. That's about five and a half hours
23 away.

24 Q. But he can order over the phone.

25 MR. MIDWALL: Form.

1 BY MR. COHEN:

2 Q. If he's told that the patient is massively
3 bleeding and her blood pressure is dropping, she's
4 in shock, and all these other things that we talked
5 about, at some point during this hour and 15, 20
6 minutes, as far as you know can he order pressor
7 agents to be given?

8 MR. MIDWALL: Form.

9 A. Yes. But he has to have nurses that are
10 qualified, that have the knowledge, training and
11 experience to administer those drugs. And that
12 would have required that patient to have been
13 transferred into one of the -- either the medical or
14 the surgical intensive care unit.

15 Q. Okay.

16 A. I have never in my career have had
17 knowledge of a labor and delivery nurse to have
18 experience or training in the use of pressor agents.

19 If there has been an indication for a
20 pressor agent, the patient would be moved off the
21 floor to a special care unit like an ICU.

22 BY MR. COHEN:

23 Q. Okay.

24 A. This is not a cardiovascular unit. This
25 is an OB unit.

1 Q. I understand.

2 Did the members of the rapid response team
3 include anybody that could order a pressor agent or
4 recommend one at least?

5 A. I don't know. I don't know the
6 credentials or limitations of --

7 All I know is that they came, they saw,
8 they left.

9 Q. When the anesthesiologist Dr. Duclas
10 arrived, and Dr. Brown at some point, do you know if
11 they gave a pressor agent?

12 A. I don't know exactly. I do not recall
13 them giving pressor agents.

14 Q. Okay. According to the record that we
15 have, at 2125, 9:25 p.m., the decision was made to
16 OR for TAH.

17 TAH is?

18 A. Total abdominal hysterectomy.

19 Q. Dr. Tomaselli notified and on his way.

20 That's because a surgeon -- you were going
21 to do surgery and you needed -- under the
22 restrictions on your licensure and privileges you
23 had to have an attending supervising doctor at
24 bedside for an operation; correct?

25 A. Yes.

1 Q. A total abdominal hysterectomy means what?

2 A. The removal -- it's the surgical removal
3 of the uterus and the cervix.

4 Q. Okay. Was that your plan?

5 A. My plan was either -- as I dictated in the
6 note, to either perform a supracervical hysterectomy
7 or a total abdominal hysterectomy.

8 Q. Okay. I'm not going to go through all the
9 blood pressures, 59/25, 67/32.

10 There's a second needle placed by
11 anesthesia at 9:30, an IV 20 gauge placed in right
12 hand by anesthesia.

13 Do you know, sir, whether a 20 gauge
14 needle is the smallest one available?

15 A. It's pretty close to it.

16 Q. Okay. Do you have any opinion as to
17 whether a larger one should have been placed under
18 the circumstances?

19 A. Absolutely. I would have expected a
20 central line to be placed.

21 Q. And that was not done?

22 A. No.

23 Q. And the reason that you would expect a
24 central line to be placed is what?

25 A. This patient needed massive transfusion

1 with large volumes of blood and other -- blood,
2 fresh frozen plasma, platelets and fluid.

3 Q. And you can't do that through a 20 gauge
4 needle effectively, can you?

5 A. No.

6 Q. And then at 2138 it says, "To OR via bed
7 for total abdominal hysterectomy."

8 MR. COHEN: Anybody need a break?

9 (Whereupon, a short break was taken.)

10 BY MR. COHEN:

11 Q. Now, Doctor, one of the things that is
12 done before you bring a patient like this to surgery
13 for hysterectomy is, you have them sign a consent
14 form; correct?

15 A. Yes.

16 Q. And, in fact, let me hand you the consent
17 form that was signed that evening.

18 And do you recognize that?

19 A. Yes.

20 Q. And do you recognize your signature on
21 that at the bottom?

22 A. Yes.

23 Q. Okay. And also either the husband or the
24 wife, I can't tell from that, frankly, but maybe you
25 can, signed it.

1 A. It was the wife.

2 Q. Okay. So she was still aware enough at
3 that point to sign for consent?

4 A. Yes.

5 Q. And the consent was for a total abdominal
6 hysterectomy, was it not?

7 A. Yes.

8 Q. It didn't say anything about a subtotal or
9 a -- or anything less than a full hysterectomy, did
10 it?

11 A. Except for line two.

12 Q. Which says?

13 A. "My physician has explained to me that
14 sometimes during the operation it is discovered that
15 an additional surgical procedure is needed
16 immediately. If I need such additional surgery, I
17 permit my physician to proceed."

18 And on the basis of that and my dictated
19 note that describes that I did speak about the
20 possibility of it being a supracervical versus a
21 total.

22 That covers the fact that it turned into a
23 supracervical, because in general the principle is,
24 you want to control the bleeding maximally as soon
25 as possible. And if that means you have to do a

1 supracervical rather than a total -- and recognizing
2 that I already knew it wasn't a cervical bleed,
3 because I'd done the things we've already talked
4 about -- that that's why -- even though it may say
5 total abdominal hysterectomy, in fact, I had
6 permission to proceed with a supracervical as well.

7 **Q. Well, to be accurate, as you just read it,**
8 **you explained there may be additional surgery**
9 **necessary, but not less than abdominal hysterectomy.**

10 **In other words, you didn't explain -- on**
11 **the consent form it doesn't say possible**
12 **supracervical or total abdominal. It says -- the**
13 **only thing it says is total abdominal and you might**
14 **need to do more surgery.**

15 **A. And, in fact, when you do a supracervical**
16 **surgery, it is more surgery. Because what you have**
17 **to do is, you have to oversee the top of the cervix.**
18 **And that's not less surgery. That's more surgery.**

19 **I know it sounds confusing.**

20 **Total only mean uterus plus cervix.**

21 **Supracervical means you leave the cervix.**

22 **But you actually -- it takes more time and you do**
23 **more operating when you do a supracervical than when**
24 **you do -- you know, when you remove the cervix.**

25 **When you remove the cervix, you just have**

1 to sew up the vaginal cuff.

2 When you do a cervical supracervical, you
3 have to sew up the cuff plus the top of the cervix
4 to establish hemostasis.

5 And, as I mentioned before, the procedure
6 I did also ablated that lower uterine segment
7 portion which I had suspected was the cause of the
8 bleeding.

9 And the reason we did it that way is so
10 that by direct visual observation I saw that there
11 was no further bleeding from that little piece of
12 lower uterine segment nor from the top of the cervix
13 that would have explained why she bled despite the
14 medication, the massage and so forth.

15 So with all due respect, sometimes the
16 word total really messes people's mind up because
17 they think total means more and subtotal means less.

18 Q. Okay. So you went into surgery.

19 And Dr. Tomaselli was he there by the time
20 the surgery started?

21 A. Yes.

22 Q. Okay. And did you discuss the case with
23 Dr. Tomaselli, as to what had happened leading up to
24 this and what you felt was going on at that time?

25 A. Yes.

1 Q. And did Dr. Tomaselli agree that she
2 needed to be taken to surgery immediately?

3 A. Yes.

4 Q. Okay. Now, the anesthesia time is a
5 little difficult to read on this record, on the
6 anesthesia record. It says the anesthesia time is
7 at 2140. But the start of the surgery says
8 something like 2201, meaning 10:01, and it ended at
9 11 o'clock.

10 Again, if accurate do you know why she
11 didn't -- that it was almost two hours from the time
12 she started bleeding to the time you started
13 operating, while she was massively bleeding, in
14 shock?

15 A. No, I do not.

16 Q. Okay. Is that acceptable to you?

17 A. I have no opinion one way or the other.

18 Q. Okay. Do you think something held you up,
19 or do you think that it was your decision-making?

20 A. No, it was not my decision-making.

21 Certainly if it were my decision-making, I
22 would have had blood there faster, I would have had
23 the operating room available quicker, I would have
24 had things that they didn't have available
25 immediately before starting; for example, they

1 didn't have the rapid blood transfuser, which is a
2 device that's used to compress blood and push it in
3 at a fast rate in there. I would have wished that
4 there had been a central line, not a 22 gauge line.

5 **Q. 20 gauge.**

6 **A. 20 gauge line.**

7 There are a lot of things -- I wish they
8 had more staff in terms of phlebotomist and blood
9 bank personnel. I wish that they would have
10 followed the orders for a massive transfusion
11 protocol, if it existed.

12 I would have loved to have had many things
13 that I didn't have the luxury of having at that time
14 in the face of an obstetrical emergency.

15 I believe everyone generally speaking did
16 the best they could as quickly as they could.

17 **Q. But, having said that, do you believe that**
18 **this time period and the things that weren't done**
19 **was within the standard of care for this lady or not**
20 **acceptable?**

21 **A. I'm not going to render that opinion.**
22 **That's for your expert to decide.**

23 **Q. It was your patient.**

24 **So do you believe -- all the things that**
25 **you just said that weren't done, that weren't ready,**

1 that they didn't have, do you believe that those --
2 was that acceptable to you, any of that?

3 A. No.

4 And I did protest later. But, as I said,
5 one of the ways they shut you down is, they
6 immediately suspend you so you can't do your own
7 internal investigation as to how did it come to pass
8 that so many things didn't meet my personal
9 standard, and to prevent you from being critical
10 outside the -- what you already knew at the time.
11 Okay.

12 For example, I would have preferred her to
13 be in a surgical ICU than a medical ICU. Certainly
14 if that were possible, I think that would have been
15 a better thing to do.

16 I learned a lot about what can't happen in
17 a facility like Good Sam. And that was one of the
18 things that led me not to reapply for privileges.

19 Q. Okay. Doctor -- you said Dr. Duclas and
20 Dr. Brown assisting were the anesthesiologists
21 during the procedure.

22 Dr. Tomaselli was the assistant --

23 A. Surgeon.

24 Q. -- surgeon.

25 Okay. And it says I think it's Dr. Duclas

1 note as opposed to Brown. It says on the anesthesia
2 record, "Patient arrived OR" -- I don't know what
3 AMS means, but I'll go to the next word --
4 "extremis, cold, clammy, blood gushing from vaginal
5 canal."

6 Is that accurate in your -- from your
7 memory?

8 A. I've never known an anesthesiologist who's
9 at the head of the table near the mouth and the face
10 to be able to visualize a patient whose legs are
11 typically strapped, blood gushing anywhere --

12 Q. Is it --

13 A. -- from a vagina.

14 Q. I mean, he could have gotten that
15 information from you, he could have gotten it from
16 the nurses, or he could have seen it before he got
17 to the operating room; right?

18 A. Well, like I said, I find that
19 interesting. I can't wait to read his depo. Let's
20 just leave it at that.

21 Q. Okay. But more importantly my question at
22 this stage is, do you disagree with that
23 characterization of her being in extremis, cold,
24 clammy, and blood gushing from the vaginal canal,
25 can you say any of that did not happen?

1 A. As I said, again, for an anesthesiologist,
2 who's, generally speaking, at the opposite end of
3 the body than the vagina, I'm not sure if what he is
4 saying -- I don't know on what basis he made that
5 observation or if that was hearsay.

6 Q. I'm not asking you to say whether it was
7 right or wrong, what he said.

8 I'm asking if you have any knowledge as to
9 whether or not you saw the same things, or you don't
10 remember one way or the other?

11 A. Oh, I remember the vaginal bleeding. I
12 just don't remember the vaginal bleeding in the
13 operating room, because at that time her legs were
14 closed and she was strapped and then she was covered
15 up.

16 Q. Okay. So during the procedure itself
17 you've already told us that you decided at some
18 point to do a supracervical, meaning above the
19 cervix, hysterectomy. But you also decided to leave
20 in a portion of the uterus, the part that had
21 actually been actively bleeding; correct?

22 A. Oh, now we're agreeing that that's the
23 part that was actively bleeding, the lower uterine
24 segment. Okay. Now that I've got that on the
25 record, thank you.

1 I just want to say this: The only way to
2 stop a blood vessel that's bleeding is to ligate it.

3 Q. Not remove it?

4 A. Well, you're going to have ligate some
5 part of it unless you -- you know, unless you remove
6 something that --

7 I mean, we don't take the heart out. I
8 mean, you've got to pick a point where you can stop.

9 Q. The heart is necessarily to live, the
10 uterus is not, it's only to have babies; right?
11 Right?

12 A. Among other things. Yes.

13 Q. Okay. So if you took out -- if you made
14 the decision to take out the entire uterus and the
15 cervix, there's no place for her to bleed from, is
16 there?

17 A. The vaginal cuff.

18 Q. But she never bled from the vaginal cuff?

19 A. She would if you cut it.

20 Q. Not if you sutured it after you took out
21 the uterus.

22 A. Same thing with the cervix or the lower
23 uterine segment.

24 In fact, there's a recognized operation
25 for controlling postpartum hemorrhage where you

1 actually leave the entire uterus in and you sew up
2 the uterus using wide sutures that you tie and
3 ligate.

4 So the spectrum of options that you have
5 range from, you leave the entire uterus in all the
6 way to you remove the uterus and the cervix. And
7 the doctor has the ability to make that judgment
8 call as to where he thinks the bleeding is coming
9 from and what is it that he actually needs to do to
10 stop the bleeding.

11 And I can tell you with certainty that she
12 was not bleeding from the lower uterine segment that
13 we left, or the top of the cervix, which we also
14 left, because by direct visualization two Board
15 certified OB/GYNs saw that there was no further
16 intra-abdominal bleeding towards the conclusion of
17 that surgical procedure.

18 Now, if you remove the cervix, you might
19 get into the bladder, you might get into the rectum,
20 you might get into adjacent tissues that could cause
21 further bleeding.

22 Having known by direct visualization that
23 her cervix was completely dry, that the bleeding was
24 coming from the inside of her uterus, by closing her
25 in the manner -- by operating in the manner we did

1 and doing the surgery exactly in the manner that we
2 did, I know with certainty that at the conclusion of
3 that operation her bleeding had stopped from her
4 uterine source. Even if we left a little piece of
5 uterus in the lower uterine segment in the body, it
6 was not going to hurt her, it was not bleeding. We
7 sutured it up under direct visualization.

8 And it was an appropriate thing to do
9 because the -- one of the guidelines is to try to do
10 whatever it takes to control where the source of
11 bleeding is thought to be coming from. And that's
12 what we did.

13 **Q. Wouldn't removing the entire uterus take**
14 **away the possibility of any further uterine**
15 **bleeding?**

16 A. Not necessarily, because, as I said,
17 within the spectrum of what's allowed, you can
18 actually leave the whole uterus in, tie off the
19 uterine blood vessels alone. You can tie up the
20 uterine blood vessels, the blood vessels that run
21 parallel to the sides of the uterus. That's
22 allowed. It's called an uterine artery ligation.
23 You can even do -- you can even leave the uterus in
24 and sew up the uterine body, the corpus of the
25 uterus, and leave the entire uterus.

1 Q. You're saying --

2 A. You're coming to a conclusion that isn't
3 supported by the evidence.

4 Q. The Department of Medicine came to the
5 same conclusion, didn't they?

6 A. Excuse me?

7 Q. The Department of Medicine came to the
8 same conclusion, that you should have done a total
9 hysterectomy.

10 A. The Department of Medicine --
11 I'm not sure I understand.

12 Q. The Department of Health, when they filed
13 a complaint against you in this case which is
14 pending right now, wrote in that complaint, and I'll
15 show it to you if you need to, that you deviated
16 from the standard of care in failing to do a
17 complete abdominal hysterectomy.

18 A. Correct. That's their opinion.

19 I remember they had an opinion once in a
20 case I was involved in where a baby was born in a
21 helicopter on the way to the hospital, and they
22 wanted to take that OB/GYN, who was waiting at the
23 hospital, license away.

24 That was the complaint that was written.

25 Q. Okay. So now when you did -- you

1 mentioned Dr. Tomaselli was there, specifically, two
2 Board certified OB/GYNs.

3 Is it your testimony that Dr. Tomaselli
4 was aware that you were leaving part of the uterus
5 and the cervix in?

6 A. I don't know.

7 Q. Okay. It was your decision, however, to
8 do so?

9 A. That's correct.

10 Q. Okay.

11 A. Because I knew with certainty, by having
12 sutured that tissue and seeing that tissue and
13 seeing -- and observing for a period of time where
14 we both watched the pelvis area, that the bleeding
15 had stopped.

16 Q. Okay.

17 A. By the way, not only did we do that, but
18 he also sewed up the uterine arteries. And the
19 uterine arteries on both sides were ligated.

20 Q. Okay.

21 A. Which is another recognized technique of
22 stopping a postpartum hemorrhage.

23 And in some cases they leave the uterus
24 inside, the entire uterus, and all they do is sew up
25 the uterine arteries.

1 Q. Have you ever done that?

2 A. Yes.

3 Q. Okay.

4 A. I've done that. I've done the sutures
5 only.

6 Q. Massive postpartum hemorrhage --

7 A. Postpartum hemorrhage.

8 Q. Excuse me. Let me finish.

9 A. Oh, I'm sorry.

10 Q. Massive postpartum hemorrhage with a lady
11 who was in this type of condition, you've -- where
12 you've thought that the bleeding was coming from the
13 uterus, you've opened them up and left the uterus in
14 and just sewed it up?

15 A. Sewed up the uterine artery. Yes, I've
16 done that.

17 Q. Okay.

18 A. Because what happens is, as what happened
19 in this case, when we actually clamped the uterine
20 artery bilaterally with I believe there were Kelly
21 clamps, her blood pressure went up. And it wasn't
22 because the resuscitation at the anesthesia level
23 had changed. It's because that was another clue
24 that the bleeding -- you know, the tributary -- the
25 blood supply leading up to the bleeding stopped at

1 the uterine artery.

2 Q. Okay.

3 A. Because her blood pressure immediately
4 went up.

5 And because of that, I knew it was safe
6 for us to perform a supracervical hysterectomy, and
7 it was appropriate for us.

8 Q. One of the other reasons that the blood
9 pressure went up is that she was finally given blood
10 products?

11 A. Not in enough quantities to justify at the
12 time of the occlusion of the uterine artery. That's
13 not the case.

14 The reason is -- it was immediately --

15 You're saying that immediately when we put
16 the clamps on those uterine arteries was at the
17 exact amount of time that a massive amount of blood
18 was transfused, in the absence of an appropriate
19 central line, in the absence of a --

20 Q. No, I didn't say that.

21 A. -- in the absence of the blood pressure --
22 blood transfuser, the rapid blood transfuser
23 machine, which was not available, and at the same
24 time that there was sufficient blood in the hands of
25 the anesthesiologist, they just coincidentally all

1 three of those things happened after we clamped the
2 uterine artery.

3 That doesn't make surgical or logical
4 sense to me as a surgeon with 30 years of
5 experience.

6 The reason her blood pressure went up was,
7 the root source, the root tributary that was leading
8 blood to go to the cervix and the uterus were
9 stopped. That's why that technique works.

10 Q. Okay. So when you finished --

11 So we're clear, just tell me if you recall
12 what part of the surgery was done by you as opposed
13 to Dr. Tomaselli, or if he did any part, or if he
14 was just standing there if you needed him?

15 A. I believe I did my side of the operation,
16 in terms of the upper vessels. He did his part of
17 the upper and lower vessels. And I did the removal
18 of the lower uterine segment while leaving her
19 cervix in.

20 Q. Now, immediately postop, while she was
21 still in the operating room, were you called back to
22 the table by either Dr. Tomaselli -- excuse me --
23 Dr. Duclas or Dr. Brown or the nurses about a
24 problem?

25 A. Yes. They were concerned about oozing

1 coming from the right side of the surgical incision.

2 Q. She was bleeding through the gauze on the
3 surgical incision, in other words?

4 A. Correct.

5 Q. And did Dr. Duclas or Brown or anyone else
6 ask you whether you should reoperate on this
7 patient, open her up again?

8 A. Would you consider that she needs to be
9 reoperated on, is I believe the question.

10 And the answer was, I would like for her
11 coagulations to be corrected before we reexplore
12 her, if it is even necessary.

13 I think that the amount of bleeding I saw
14 clinically -- because I did go back into the
15 operating room and observe what they were observing.

16 I wanted to put the pressure dressing on,
17 which was an abdominal binder, which is like a
18 girdle, big girdle, and then a big girdle with an
19 ice pack, to see if the bleeding was being caused by
20 the edge of what we had cut with a scalpel or
21 whether it was some other type of bleeding.

22 Q. Okay.

23 A. Now, because we did that did not mean that
24 we excluded completely the possibility of
25 re-exploration if it was indicated.

1 But at that time her vital signs were
2 normalized, her oxygenation, I was told, was
3 normalized, her -- when I say her vital signs, I
4 mean her blood pressure and pulse. The urine that
5 she was actually producing in the Foley bag, the
6 fresh urine was clear, not blood tinged.

7 So on the basis of the hemodynamic status,
8 even though she may have had some edge bleeding or
9 bleeding maybe a little bit below the skin, I felt
10 that that could be treated conservatively initially,
11 but not to the exclusion of having to reexplore her.

12 And I was reassured, actually, at that
13 time, because Dr. Duclas says, well, okay, I'm going
14 to stay here tonight and I'm going to keep an OR
15 team available in the main OR in the event you
16 change your mind.

17 And I said that would be fine. If
18 something changes, then we'll reexamine the
19 situation and go from there.

20 Q. Okay.

21 A. And I placed orders, including a repeat
22 blood count to be done as part of the postoperative
23 orders.

24 Q. And --

25 A. And the transfusions were in progress at

1 that time.

2 But unbeknownst to me, because I didn't
3 really look over the top of the curtain, there was
4 no central line.

5 **Q. And there was no platelets being given?**

6 A. There was no platelets being given. There
7 was no fresh frozen plasma being given at the time I
8 last saw the patient in that room. And there was no
9 rapid blood transfusion -- rapid blood infuser
10 device, which is a bag pressure device that would
11 push blood in quickly.

12 **Q. And there was no central line to push it**
13 **through?**

14 A. That's right.

15 **Q. And whose job is it to do that in this**
16 **case?**

17 A. Well, I'm going -- I would generally defer
18 that to the anesthesiologist Dr. Brown or
19 Dr. Duclas.

20 I would never have expected Dr. Tomaselli
21 to go to the head of the table and start a central
22 line, because it's out of our -- we're not allowed
23 by the permissions that a hospital allows us to
24 do -- neither he nor I could have put in a central
25 line.

1 Q. So that being the case, and the fact that
2 there was two anesthesiologists there --

3 A. In the OR. Yes.

4 Also, I've seen intensivists put in
5 central lines. And I've seen interventional
6 radiologists put in a line.

7 Q. In this particular case, however, you
8 believe that a central line should have been
9 inserted even before surgery; correct?

10 A. Correct.

11 Q. And that the only people there that were
12 present that would have done that would have been
13 the anesthesiologists?

14 A. Correct. Of the people that I saw there,
15 yes.

16 Q. And it wasn't done?

17 A. No, it wasn't done.

18 Q. Did you ever question why it wasn't being
19 done at the time, or did you not know?

20 A. During the surgery I actually asked are we
21 putting in a central line.

22 Q. You asked Dr. Duclas?

23 A. They were both there.

24 Q. And Brown?

25 A. They said not yet.

1 Q. Okay. Any more discussions about that
2 between you and the anesthesiologists?

3 A. No, not that I can recall.

4 Q. Okay. Dr. Duclas' note, postoperative
5 note is that her main medical issue was that she had
6 blood seeping through her incisional wound. The
7 wound bleeding was brought to the surgeon's, in
8 parentheses, Dr. Lopez, attention by the nurse, the
9 OR nurse and myself, because we were concerned about
10 internal bleeding, but deferred to the surgeon to
11 make the appropriate assessment. We called the
12 surgeon back into the operating room. Upon
13 inspection of the incision, the surgeon did not
14 think that reopening the patient while she was in
15 the OR was necessary and he ordered the wound to be
16 compressed with an abdominal binder.

17 That's what you told us already; correct?

18 A. Yes.

19 Q. "I informed the surgeon that internal
20 bleeding could be worth considering with more
21 suspicion because" --

22 I'm sorry. Dr. Duclas's note goes on to
23 say --

24 A. Okay.

25 Q. -- quote, I informed the surgeon that

1 internal bleeding could be worth considering with
2 more suspicion because of the majority of blood
3 control may have occurred under hypotensive
4 conditions and since the patient's blood pressure
5 was since normalized, there may be a new vascular
6 bleed that may not be present and worth further
7 investigation or reopening. He still thought
8 binding was appropriate. So the patient was
9 transported from the OR to the ICU as planned and
10 with binding as ordered by the surgeon.

11 Do you remember the second part of that
12 conversation that Dr. Duclas noted, that he raised a
13 concern?

14 A. Yes, he did.

15 Q. As he said, you decided that despite what
16 he said you didn't think it was -- the operation was
17 appropriate at that time?

18 A. Correct. That was correct.

19 Is this 5 o'clock in the morning note?

20 Q. No.

21 I don't know the note --

22 It's timed -- dictated, according to this,
23 at 27 minutes after midnight. It is --

24 There's 4:30 -- that's a different note.

25 A. What page is it on?

1 Q. 6 o'clock in morning. You're right.

2 A. Oh, so this is after she was already dead
3 when he dictated this; right?

4 Q. Yes.

5 A. Okay. So this was the note he dictated to
6 cover his ass after she was dead.

7 Q. I see.

8 A. Keep going. That's fine. I remember.
9 I read this note.

10 No, so far I agree up to the point that
11 you read.

12 Q. Okay. "Upon arrival in the ICU the
13 patient was stable, but still having blood stained
14 abdominal pads or her wound when checked by the OR
15 nurse, but it was similar to the bleeding that was
16 shown to the surgeon while the patient was still in
17 the OR."

18 Again, is that consistent with your
19 thinking that she didn't need to go back or --

20 A. That and more. Because in real time
21 before she died, I had actually called and spoken to
22 the OB nurse Ryan, who I asked -- and I'm going to
23 guess that was a little bit past midnight. I had
24 left the hospital. I called to check on the
25 bleeding, the abdominal bleeding status. And she

1 had said that it had improved or stopped. She had
2 not gotten more information otherwise. And I had
3 asked about the labs that I had ordered
4 postoperatively, and I believe she went to the
5 computer, and they weren't back yet.

6 Q. Okay. Should they have been?

7 A. I don't remember the time -- you know, my
8 time gets a little bit warped in terms of when my
9 order went in, I don't know if it was -- I ordered
10 them two hours or four hours, but I could look and
11 find out.

12 Q. Okay. So Dr. Duclas's note goes on
13 continuing from where I left off, quote, there was
14 no visible change in the size of the abdomen or any
15 tightness or firmness felt by me or the nurse
16 providers. Abdominal binding persisted. I chose to
17 remain in the hospital despite being able to
18 continue call at home because I was still concerned
19 about the possibility of re-bleed internally under
20 the binding. I did not retreat to my call room
21 unless I had witnessed the patient make purposeful
22 movements and respond to the ICU nurse's voice. At
23 one point I was informed about a blood gas that was
24 suggestive of a metabolic acidosis, but the therapy
25 was being handled by the ICU team already with

1 fluids, bicarb and pressor drip was started -- was
2 going to be started. However, patient
3 decompensated.

4 And, you know, they talk about the code.

5 A. Okay.

6 Q. So you're saying --

7 And, also, I'll read it if you need me to,
8 the nurse noted that -- the same thing as
9 Dr. Duclas, that she called you and was worried
10 about beading and that she saw you walking out of
11 the hospital. There's a to that affect.

12 Is that accurate, that you did leave the
13 hospital after surgery?

14 A. Yes, I did.

15 And let me tell you why. I actually had
16 saturated one of my -- my scrub pants the lower
17 portion below the knee of my scrub pants in blood,
18 and there were no fresh scrubs in the call room. So
19 I left the hospital to go home to get out of the
20 blood soaked scrubs. Additionally, my sock and my
21 shoe were filled with blood clot from
22 Miss Castillo-Lopez. So in order to wash myself, I
23 went home.

24 I knew that I left her in the hands of two
25 anesthesiologists, an intensivist, an experienced OB

1 nurse Ryan, who I'd worked with for years, who was
2 used to recovering postop cesarean section patients
3 on a regular basis. And from my conversation in the
4 medical ICU by phone with an experienced but young
5 medical ICU nurse, and I had asked them about the
6 bleeding, the abdominal speeding and the vital
7 signs.

8 Q. Okay.

9 A. So while I may not have been physically
10 present, I also knew that inside that hospital there
11 was a hospitalist, an M.D. that had heard about the
12 previous code, rapid response code.

13 Q. Okay.

14 A. So I felt comfortable that if I wasn't
15 physically in the hospital that I could promptly be
16 physically in the hospital if the vital signs or
17 there was a need that arose.

18 I was never called or contacted by the
19 nurses, by Dr. Duclas or the hospitalist or the
20 intensivist or the ICU nurse at any time. I called
21 them. They never called me.

22 In fact, I called a second time because
23 the labs were not back the first time I called, and
24 I got the reports of the lab work, which seemed
25 reasonable on the basis of the amount of blood that

1 I had queried the ICU nurse, the MICU nurse. I'm
2 trying to remember her name. But -- not Ryan, but
3 the one that was there that had kept up the count of
4 how much blood she had received.

5 Q. Vida Joseph?

6 A. That's right.

7 Q. Miss Joseph noted that she received the
8 patient in the ICU from the OR at about it says
9 midnight, 0000 hours. Report received from
10 Dr. Duclas. Patient intubated. No sedation.

11 Was the patient intubated before the
12 hysterectomy?

13 A. Yes.

14 Q. Okay. And she said that the patient had
15 tachycardia in the 140's on the monitor, hypotension
16 noted, so a two liter bolus infusing per anesthesia.
17 Abdominal dressing saturated with bloody drainage.
18 And abdominal binder in place. Dressing removed and
19 changed with anesthesia present at bedside. The
20 abdominal binder was reapplied. Bloody drainage
21 noted draining into Foley as well as out of the
22 vagina. Fresh peri-pad applied. Intensivist noted
23 of patient and seen on Nuview. Will continue to
24 monitor and carry out orders.

25 Is that information -- anything in that

1 information new to you, information that you didn't
2 know about?

3 A. What time was that note written?

4 Q. Midnight.

5 A. Okay. I had called shortly after midnight
6 and received a different kind of report.

7 That would have been the first dressing
8 change.

9 I did not expect the vagina to be
10 100 percent absolutely hemostatic for two reasons;
11 in addition to the cervical lacerations which I
12 repaired, I repaired a perineal laceration, a second
13 degree vaginal laceration from the birth of the
14 child. This was not a laceration that I had cut.
15 It's not episiotomy, where the doctor actually cuts
16 it. This is where the patient had actually torn.
17 And at that time the labs were not back.

18 So depending on her degree of treatment of
19 her coagulopathy, okay, because obviously it would
20 not surprise me in the least bit that she was in DIC
21 of one form or another, some vaginal bleeding was
22 going to be appropriate for the laceration she had
23 in her vagina. The vagina is extremely vascular
24 after you have a child. You do not expect the
25 vagina not to have bleeding.

1 I was not told that her bleeding was of a
2 quantity concerning, because I also had spoken to
3 Ryan, the labor and delivery nurse, who had, you
4 know, participated in cesarean sections and
5 postpartum female care for a number of years.

6 So on the basis of that information I felt
7 that even though the patient was still recovering
8 from her acute postpartum hemorrhage that it did not
9 require my reopening her abdomen, resuturing her
10 vagina until I knew the results of her coags,
11 because if this bleeding was due to lack of
12 platelets or lack of the blood components, if it was
13 an abnormal PT or PTT or abnormal platelets, those
14 have need to be corrected. Because before I would
15 have suggested that those would be solely due to
16 lack of suture hemostasis. I asked about the
17 abdominal cavity, whether it was distended, and the
18 answer was no.

19 **Q. When the labs came back were you notified**
20 **of what they were?**

21 A. I called to get the labs, yes. And they
22 were somewhat reassuring.

23 **Q. Okay. Was --**

24 A. With the exception of the platelet count
25 of 60,000.

1 Q. I was going to ask you that. So tell
2 me --

3 A. But she was under the care --

4 Q. Her platelet count when she came in was
5 like 160, which is normal --

6 A. Excuse me. When she came into the
7 hospital, you're talking about the her first
8 platelet count?

9 Q. Yes.

10 A. I think it was higher than that.

11 Q. Okay. But it was within normal range?

12 A. Yes.

13 Q. Sixty is a huge drop from what it was when
14 she came in?

15 A. Yes, sir. That's correct.

16 But in the light of the circumstances of
17 her postpartum hemorrhage --

18 Q. But why not give platelets to replace that
19 so that you can help avoid DIC or treat it?

20 A. Excellent question.

21 And the answer is as follows: The
22 guidelines for transfusion has changed a lot. We
23 used to transfuse to a hematocrit greater than 30.
24 Now you can be 22 before a transfusion could be
25 given. This is from the American College of

1 Pathology and the hospital policies as implemented,
2 to diminish the number of transfusions that are
3 given.

4 Spontaneous bleeding typically will occur
5 with a platelet count below 50,000. So a 60,000
6 platelet count, I'm not going to say to you that
7 everybody would transfuse with platelets at a 60,000
8 count.

9 With someone who just went through a heavy
10 bleed would I've expected more aggressive blood
11 product readministration?

12 Maybe.

13 But could I be critical?

14 Well, as I said, I've sat on committees
15 that does reviews for a number of years, and when
16 there was this new change in the numbers that we use
17 for absolute transfusion, it goes into that judgment
18 call circumstance, how is the patient doing
19 clinically in addition to the numbers.

20 A hemoglobin greater than 21, would I
21 expect absolutely for more blood to be given?

22 Not necessarily.

23 A platelet count of 60,000, higher than
24 50,000, definitely needs to continue to be trended.

25 If she had evidence of active bleeding

1 that was important or significant, absolutely I
2 would have expected more blood.

3 But I had the eyes of an intensivist,
4 Dr. Duclas, who in his postmortem note notes that he
5 was there. I would assume he went by and took a
6 look at the patient himself and took a look at the
7 labs on the computer himself, because he was there,
8 he's physically there. And I received the reports
9 by phone.

10 And I felt reassured -- more reassured by
11 what I heard from Ryan rather than -- I apologize
12 for the ICU's name, but I forgot her name. But Ryan
13 I knew quite well.

14 **Q. Well, was the patient neurologically was**
15 **she awake, alert, responding?**

16 A. The report I got -- I was not physically
17 there --

18 **Q. I understand.**

19 A. The report I got is, at first there was a
20 concern about that. But she had showed response to
21 commands. In other words, she was asked to squeeze
22 fingers. I believe one of her relatives at the
23 bedside asked her to squeeze their hand, and they
24 did in response to her name being called. I also
25 heard from the nurse that there was purposeful

1 movement, there was following an order that the
2 nurse gave to the patient.

3 And to me that was indication that there
4 was no brainstem injury, that there was no -- that
5 her cerebral cortex, which is what has to be
6 functional for you to move muscles, okay, especially
7 under instruction, so that means that the very top
8 surface of her brain, which is the area that is most
9 susceptible to hypoxic injury, because it's the one
10 part of your brain that is the furthest away from
11 the blood supply, okay, if you're told to do
12 something, then the auditory portion of your brain
13 is working if you respond. Okay. So we know her
14 ears and the nerves that go from her ears to the
15 middle part of her brain that go to the surface of
16 the brain and the feedback loop all the way back
17 down were functional.

18 **Q. Okay.**

19 A. She was not brain dead. She would not
20 pass a brain death test, because she had purposeful
21 movement after instruction by a relative and by a
22 trained professional.

23 **Q. Okay. Nurse Vida noted at midnight, which**
24 **is when she received the patient, that she had no**
25 **gag reflex and no cough reflex. She noted that the**

1 patient was obtunded. She noted that the patient
2 was flaccid, best motor response was flaccid. Best
3 verbal response was none. She was intubated. Best
4 eye opening response none.

5 At 1 o'clock the same things.

6 At midnight, again, she's noted unable to
7 follow commands. No wiggling of toes right or left,
8 or fingers right or left.

9 Again at 1 o'clock the same thing, there
10 was no following commands.

11 At midnight unable to move any of her
12 extremities. Oral assessment, description bleeding
13 midnight.

14 A. Oral?

15 Q. It says oral assessment.

16 A. Like O-R-A-L?

17 Q. Yes.

18 A. Okay. I'm sorry.

19 As opposed to A-U-R.

20 Q. O-R-A-L.

21 Assessment, description bleeding.

22 There was blood -- her urine was bloody,
23 quote, unquote. And her pupils equal and reactive
24 to light, no. Extraocular movements unable to
25 assess. Blinks to threat absent. 2 millimeter

1 pupils on both sides not reacting.

2 Were you told that, all of that?

3 A. No.

4 Q. What were --

5 A. I was told that there was purposeful
6 movement. Because there had been an order written
7 for either -- I believe it was a CAT scan if there
8 was an the absence of a purposeful movement after a
9 time. I do not recall what time that was.

10 And I had asked -- I called somewhere
11 maybe 2:00, 2:30, I called from home. And the
12 report I got that the CAT scan was not performed
13 because she was showing evidence of recovery and
14 purposeful movement.

15 Now, I believe even in Dr. Duclas's note
16 that you had quoted from 5 or 6 o'clock in the
17 morning -- I don't know what page that's on -- but
18 he even indicates that there was purposeful movement
19 and a decision not to proceed with a CAT scan. They
20 decided to give her more time to see whether she
21 responded better or more.

22 Q. Well, what does everything I just read to
23 you from the Nurse Vida's note at -- the intensive
24 care unit nurse who took her, all the things I just
25 read to you that were absent, movements, voluntary

1 movements, pupils, responses, everything I just read
2 to you, what would that indicate to you as opposed
3 to what you just said about her condition?

4 MR. MIDWALL: Form.

5 A. Well, we're talking about two different --
6 two different evaluators. We have an
7 anesthesiologist who puts people to sleep and
8 immobilizes them on purpose, who watches them wake
9 up after they come out of say vascular surgery
10 versus a medical ICU nurse's documentation.

11 The report I got was more consistent with
12 what I believe Dr. Duclas wrote in his 5 o'clock,
13 6 o'clock in the morning note, or dictated in his
14 5 o'clock, 6 o'clock note, than what Nurse Vida had
15 relayed.

16 And when I came in after she had arrested
17 and spoke to the family, I had also got reassurance
18 that she was showing, you know, movement, purposeful
19 of moment of some sort. And I believe it was hand
20 squeezing on command with a relative, her husband.
21 It might have been her mother.

22 BY MR. COHEN:

23 Q. That's not in the record. That's what you
24 remember?

25 A. That's what I had heard.

1 I'm telling you --

2 Yes, I did not document it. She had
3 already passed.

4 But I had heard -- I had heard from I
5 believe it was Ryan that she had had evidence of
6 purposeful movement and as such they thought she was
7 improving.

8 There's no question she was critically ill
9 when she came into the ICU.

10 Q. So we know what the labs looked like at
11 1:30 or such in the morning. We talked about that a
12 bit.

13 Did the intensivist, who was called by the
14 Nuview system, ever speak with you?

15 A. No.

16 Q. Did -- at 3 o'clock did her condition get
17 worse, do you know?

18 A. Yes. It acutely -- she acutely
19 deteriorated.

20 Q. What do you think --

21 A. Hyper acutely.

22 Q. Did she have a metabolic acidosis?

23 A. Yes. But that was being corrected.

24 Q. What was causing it?

25 MR. MIDWALL: Form.

1 A. I would imagine that she had sustained an
2 acute severe hemorrhage.

3 BY MR. COHEN:

4 **Q. Where?**

5 A. Well, in her -- through her uterus. She
6 had had profound blood loss and she had an acidosis
7 that needed to be corrected, in addition to all the
8 other metabolic elements that might have needed to
9 be corrected, which is not uncommon after a
10 postpartum hemorrhage.

11 **Q. So what caused the acute change in her**
12 **clinical condition, as you put it?**

13 MR. MIDWALL: Form.

14 A. I don't know exactly. I can't say.

15 BY MR. COHEN:

16 **Q. Okay. Other than the massive bleed that**
17 **she had sustained and the lack of platelets and**
18 **central lines, the things that you talked about in**
19 **the intensive care unit, whatever it was, other than**
20 **the massive bleed that she had, what else could have**
21 **caused her death, other than the massive bleeding,**
22 **in your opinion?**

23 MR. MIDWALL: Form.

24 A. My first impression was, I wonder if she
25 sustained an acute pulmonary embolism.

1 In fact, the first person who suggested
2 that to me was her aunt, Dr. Irma Lopez, when she
3 came in. Because she, like I, had called in to get
4 the results of the laboratory testing. And she,
5 like I, was under the impression that she had
6 regained purposeful movement. And her labs, while
7 still not as they were when she was admitted, were
8 certainly understandable in light of the amount of
9 bleeding and resuscitation that she had had. It
10 would be consistent with the amount of bleeding and
11 the amount of resuscitation that she had sustained.

12 **Q. She therefore died from the massive**
13 **postoperative -- post-delivery hemorrhaging that she**
14 **had and the sequelae of that is what caused her**
15 **death, more likely than not; correct?**

16 MR. MIDWALL: Form.

17 A. Again, in light of not having additional
18 review of her pathology slides, I would say it
19 needs -- by another pathologist, I would say it
20 remains to be determined as to her exact cause of
21 death.

22 BY MR. COHEN:

23 **Q. Well, we know it wasn't a pulmonary**
24 **embolus, because it was looked for by the**
25 **pathologist and it wasn't found; correct?**

1 A. As I mentioned before, only one
2 pathologist has taken a look at some of the
3 evidence. I don't know that everyone's -- I don't
4 know that a second expert that would review this
5 case would come to the same or different conclusion,
6 because they've not had the opportunity to review
7 the clinical history or the pathological evidence
8 that we know exists.

9 Q. Well, actually she did. She mentions the
10 medical records and then quotes from them at the
11 time of her dictation, and -- somewhat at length.
12 And she specifically looked at the lungs to see if
13 there was any evidence of pulmonary embolus and
14 there was not.

15 Are you questioning that?

16 A. As I may have mentioned before, I've been
17 in this community 30 years and I've read more than a
18 few postmortem reports from the local, meaning the
19 Palm Beach County Coroner's Office, and I've seen
20 some reports that were consistent with subsequent
21 evaluations by independent medical examiners and
22 I've seen a wide discrepancy between interpretations
23 between separate pathologists.

24 I am reluctant to accept a single opinion
25 just by this -- not necessarily because it's my

1 case, but because I've seen times that others have
2 found things and looked for things that were the
3 cause of death that were heretofore unknown at the
4 time or have subsequently developed by further
5 investigation of the same specimen.

6 So I'm just saying I'm going to withhold
7 my judgment.

8 I saw what she wrote. Just like I've seen
9 reports of the amount of pressure that the CPR
10 machines placed in terms of the centimeters of
11 compression that you get when you use a machine,
12 CPR machine versus a human CPR effort. And in some
13 cases the amount of arterial pressure that gets
14 generated is sufficient to blow off recently placed
15 sutures.

16 So the blood that's accumulated is
17 perimortem, not antemortem.

18 **Q. Is there any effort --**

19 **Well, first of all, do you think the**
20 **patient had DIC at any point?**

21 **A. I didn't look to -- I didn't really look**
22 **at that in any sort of serious way.**

23 **Q. What is it with this patient's ongoing**
24 **problems, the bleeding problems that she had, that**
25 **would lead to a pulmonary embolus?**

1 I mean, the platelet count was low, not
2 high.

3 A. Right.

4 But what sometimes can happen is, there's
5 a stasis that's caused -- the stasis of blood.

6 Q. Right.

7 A. What I mean by that is, patients who
8 become hypotensive may actually have pooling of
9 blood.

10 In obstetrics when you give a patient an
11 epidural, you basically diminish the amount of blood
12 pressure that exists in the lower extremities.
13 That's one of the consequences of an epidural. Many
14 times they get hypotensive.

15 In fact, that's why the anesthesiologists
16 generally hang around awhile after they put in and
17 dose an epidural.

18 This patient had a epidural.

19 Sometimes the blood pressure drops so much
20 that they have to give ephedrine, and it's part of
21 their standing orders, if there's a hypotensive
22 episode.

23 When you have pooling of blood, you
24 increase the likelihood of a clot to form, whether
25 it's caused by low blood pressure from an epidural

1 or low blood pressure from a postpartum hemorrhage.

2 She definitely had low blood pressure
3 multiple times for one reason or another. And that
4 predisposes that patient to form a clot. And if
5 that clot goes to the lungs, that's what we call a
6 pulmonary embolism.

7 **Q. And that's something that you see on**
8 **autopsy?**

9 A. Depends on how careful the specimens are
10 looked at.

11 **Q. Okay. And this lady's last fibrinogen**
12 **study was 62.**

13 **Normal range 200 to 400.**

14 **What does that tell you?**

15 A. That she's probably in DIC.

16 **Q. Okay. So somebody in DIC is not going to**
17 **be clotting, it's the opposite of clotting, it's**
18 **where the blood can't clot; right?**

19 A. Okay. And I'm going to tell you, patient
20 care is a movie. And you're looking at a blood
21 test. A blood test is a photograph of one moment in
22 time.

23 If the blood clot formed during the time
24 that she got her epidural and had a drop in her
25 blood pressure, that was corrected by a fluid bolus,

1 a blood clot could be formed and be waiting there
2 while her clotting factors were all relatively
3 normal.

4 Q. Not normal. They were abnormal in a way
5 that showed that she wasn't clotting.

6 A. Sir, that photograph was taken towards her
7 death.

8 Q. 1:20.

9 A. When you take a photograph of what was
10 going on in her lower extremities after she got the
11 epidural and her blood pressure dropped, which is a
12 sign that the epidural is doing exactly what it's
13 supposed to do --

14 Q. What does that have to do with 1:20 in the
15 morning, the epidural?

16 A. Because if a clot formed --

17 Q. Hang on.

18 You're talking about the last blood test
19 that was done on her at 1:20 -- collected at least
20 at 1:20 in the morning, reported after 2:00, 2:23 in
21 the morning. Critical values, it says, with a
22 fibrinogen of 62, a PTT of 61, a PT of 18, and an
23 INR of 1.8, all abnormal.

24 Those are all evidence that she has less
25 than normal clotting factors, that she's less likely

1 **to clot, not more likely?**

2 A. At that time.

3 **Q. At 1:20, yes.**

4 A. At that time. Okay.

5 **Q. What --**

6 A. What if we took -- what if her low blood
7 pressure caused stasis of blood in her legs when she
8 was undergoing the acute bleed?

9 What if the low blood pressure caused a
10 pooling of blood when her coagulation factors were
11 normal at the time of her epidural?

12 If it happened at the time of the
13 epidural, if it happened at the time of her
14 hypotension during her bleed, clots can form that
15 won't be released necessarily instantaneously.

16 The other thing is, that when you have a
17 patient pushing a baby out, you put their legs up.

18 And in her case her legs were up. It's a
19 position called semi-phallus. Her legs are elevated
20 in stirrups and strapped, because she's numb from
21 the epidural, and her legs are elevated. And that
22 elevation -- that antigravity elevation also causes
23 pooling of blood in the calves, and a clot can form
24 at that time.

25 **Q. What evidence do you have of that at all?**

1 Any piece of evidence, show me one piece
2 of evidence in this chart that somewhere during
3 delivery she had a DVT?

4 A. And my answer is this: I'm not saying
5 that I know the cause of her death. Her death to me
6 seems to fit a pattern that I've seen in another
7 case that was similar to this, where there was no
8 postpartum hemorrhage, and it was actually caused by
9 a blood clot that had formed in a patient with an
10 epidural with her feet up.

11 Q. That has nothing to do with this case,
12 Doctor.

13 A. And the first pathologist -- excuse me --
14 the first pathologist said no pulmonary embolism.
15 And another pathologist demonstrated that there was.

16 Q. But that lady wasn't bleeding to death and
17 needed --

18 A. I get that. I get that.

19 Q. And didn't have clotting factors which
20 showed that she was not only anticoagulated or
21 anti-platelets were high, but that she was, in fact,
22 DIC, which is the opposite of clotting.

23 So I'm sure there's, you know, stories of
24 a lot of people.

25 But this lady didn't have any evidence, in

1 fact, had reverse evidence of that happening;
2 correct?

3 A. Only based on one medical examiner's
4 report.

5 Q. No.

6 And based on the laboratory reports that
7 she had.

8 And not one single person in the medical
9 record wrote that she had a pulmonary embolus, did
10 they?

11 A. Well, let me refer you to this page.
12 Very interesting you should mention that.
13 But I think over here, and I'm going to
14 have flip some pages --

15 Q. Okay.

16 A. You're going to have to give me a moment.
17 We might even have to go off the record.

18 Q. Okay. Let's go off the record for a
19 minute.

20 (Whereupon, an off the record discussion
21 was held.)

22 THE WITNESS: On page 72 of my Bate
23 stamped record.

24 After a discussion with Dr. Irma Lopez,
25 who had also received the same lab information

1 approximately at the same time I did, sometime
2 around 2:00 in the morning, somewhere before
3 2:00 to 2:45, pulmonary embolism is checked off
4 as the preliminary cause of death. And this
5 record --

6 BY MR. COHEN:

7 Q. By who?

8 A. It says by the --

9 Did attending physician indicate
10 preliminary cause of death?

11 The answer was yes. And it says pulmonary
12 embolism.

13 BY MR. COHEN:

14 Q. Excuse me. May I?

15 A. Sure.

16 Q. Who was that physician?

17 A. They called me. She said Berto Lopez.

18 Q. Right.

19 You came up with that idea; right?

20 Not anybody else.

21 A. No. Irma Lopez, her aunt.

22 Q. Irma Lopez is a family practitioner who
23 would have -- can speculate all she wants -- would
24 have no knowledge of pulmonary embolus. And she
25 didn't know all the bleeding factors. And she

1 didn't know how much she had bled and all that other
2 stuff.

3 You're the one who signed off on this as
4 being a potential pulmonary embolus, not anybody
5 else; right?

6 A. My name doesn't sign off -- I don't see my
7 signature anywhere on that page.

8 The reason that exists is because Irma
9 Lopez and I spoke with Vida Joseph, and at that time
10 that was her and my initial conclusion of the cause.
11 And it is in writing. And I guess this page is
12 called Expiration and Release of Body, page 1 of 2.

13 Q. She actually had a cardiac, not a
14 respiratory arrest.

15 She was intubated at 3 o'clock; correct?
16 She had already been intubated.

17 And they checked off cardiac arrest and
18 left off respiratory arrest. Didn't check that box.

19 Doesn't that tell you something?

20 A. I have no opinion about that.

21 Q. Well, if you have a pulmonary embolus, you
22 have a respiratory arrest primarily and then
23 cardiac, you don't have a cardiac arrest first;
24 right?

25 A. Again, I'm not an expert on either of

1 those.

2 Q. Okay.

3 A. This was what I was -- when I spoke with
4 Dr. Irma Lopez --

5 Q. Dr. Irma Lopez is not an expert witness
6 and she's not an expert at all on any of this.

7 She's a family practitioner; correct?

8 A. I'm just relaying what she said.

9 Q. Would you take her word or her guess over
10 that of a -- someone who did the autopsy?

11 A. Well, again, it depends on who that person
12 that did the autopsy and with what care.

13 Q. She's been doing autopsies for 30 or 40
14 years, this lady. And she, by the way, does not
15 work for the Palm Beach County Medical Examiner's
16 Office. She's an independent medical examiner.

17 A. I'm sorry.

18 Q. But she did the autopsy. She had the
19 lungs in her hands, both macroscopically and
20 microscopically, and found no evidence of a
21 pulmonary embolus; correct?

22 A. That's what her report says, yes.

23 Q. Okay. And according to the code blue
24 sheet, which was filled out by the -- one of the
25 nurses, Vanessa -- excuse me -- there was a doctor

1 there, Vanessa Vasquez. There were nurses there who
2 recorded things, including this specific note, she
3 recorded this. The etiology was cardiac arrest at
4 3:00 a.m. Respiratory is left unchecked. It was
5 witnessed at 3:00 a.m. She had pulseless electrical
6 activity. And CPR was started. And they gave
7 various medications to try to bring her back, but
8 unsuccessfully, for 55 minutes.

9 And nobody in that room said anything
10 about a pulmonary embolus, did they?

11 A. Not on the record, no.

12 Q. Did any of them say that off the record to
13 you?

14 A. Yes. I told you, Dr. Irma Lopez.

15 Q. Dr. Irma Lopez was not one of the doctors
16 in the code blue, Doctor.

17 A. Correct.

18 Q. I'm asking you about the doctors who
19 performed the code blue, did any of them say they
20 thought it was a pulmonary arrest or pulmonary
21 embolus, either one?

22 A. I did not speak with Dr. Vasquez.

23 Q. Okay. You were there when she died, were
24 you not?

25 A. No. I came after she was dead.

1 Q. I thought I read in the records somewhere
2 that you were there during the code.

3 You're saying you were not?

4 A. I was there at the end of the code,
5 towards the end of the code. Correct.

6 Q. That's what I'm getting at.

7 A. I pronounced her dead after 45 minutes of
8 resuscitative efforts.

9 Q. Right. Okay. That's all I was asking.

10 A. Yes.

11 Q. Is it your testimony that -- after
12 everything we've gone over today that you don't know
13 whether or not she died as a result of the massive
14 bleed that she had?

15 A. I am -- I have no opinion at this point
16 pending further review as to the exact cause of
17 death.

18 Q. Okay. The medical examiner Dr. Price
19 indicated that she had retained lower uterine
20 segment, with raggedy cervix containing multiple
21 sutures, on autopsy.

22 Do you have any reason to disagree with
23 that?

24 A. I was the one that placed those sutures.

25 Q. Right. That's why I was saying do you

1 have any reason to disagree --

2 A. No. That was intentional.

3 Q. Yes. I understand that.

4 She also had a hemoperitoneum, 1500 cubic
5 centimeters of liquid blood in the peritoneum.

6 Any reason to disagree with that?

7 A. No.

8 Q. She said that one of the causes of death
9 was hemorrhagic shock with multi-organ failure.

10 Any disagreement with that?

11 A. No.

12 Q. And that she had evidence of DIC?

13 A. I agree with that.

14 Q. So her final opinion that she wrote as to
15 the cause of death was, she was a 40 year old female
16 who died as a result of complications of hemorrhagic
17 shock with multisystem -- multi-organ failure and
18 DIC due to postpartum hemorrhage due to uterine
19 atony.

20 You wouldn't agree with any of that, would
21 you?

22 A. No.

23 MR. COHEN: Okay. All right. I don't
24 think I have any further questions for you at
25 this time, sir.

1 Anyone else?

2 CROSS EXAMINATION

3 BY MR. BARKER:

4 **Q. Dr. Lopez, my name is Alex Barker, and I**
5 **represent Dr. Tomaselli.**

6 Do you have any criticisms as it relates
7 to Dr. Tomaselli?

8 A. No, I do.

9 MR. BARKER: Thank you. That's all I
10 have.

11 CROSS EXAMINATION

12 BY MR. MIDWALL:

13 **Q. And I think you testified earlier you had**
14 **no criticisms about any of the other medical**
15 **providers in this case; is that correct?**

16 A. That's correct.

17 MR. MIDWALL: I've got nothing else.

18 MR. CHIMPOULIS: No questions.

19 REDIRECT EXAMINATION

20 BY MR. COHEN:

21 **Q. Other than the ones you already provided,**
22 **correct, Doctor?**

23 A. Yes, sir. That goes without saying.

24 MR. COHEN: Okay. You have the right to
25 read this deposition or waive the reading and

1 signing of the deposition.

2 THE WITNESS: I would like to read it.

3 You're in palm Beach County; correct?

4 MR. COHEN: Phipps Reporting.

5 (The proceedings concluded for the day at
6 3:14 p.m.)

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CERTIFICATE OF OATH

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STATE OF FLORIDA

COUNTY OF PALM BEACH

I, the undersigned authority, certify
that BERTO LOPEZ, M.D. personally appeared before
me and was duly sworn on the 10th day of January,
2019.

Signed this 12th day of January, 2019.

Richard Applebaum

RICHARD APPLEBAUM, RMR, FPR, CLR
Notary Public, State of Florida
My Commission No. FF 243089
Expires: 08/06/19

CERTIFICATE OF REPORTER

STATE OF FLORIDA

COUNTY OF PALM BEACH

I, RICHARD APPLEBAUM, Registered Merit Reporter, do hereby certify that I was authorized to and did stenographically report the foregoing videotape deposition of BERTO LOPEZ, M.D.; pages 1 through 197; that a review of the transcript was requested; and that the transcript is a true record of my stenographic notes.

I FURTHER CERTIFY that I am not a relative, employee, attorney, or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorneys or counsel connected with the action, nor am I financially interested in the action.

Dated this 12th day of January, 2019.

Richard Applebaum

RICHARD APPLEBAUM, RMR, FPR, CLR

1 January 12, 2019

2 BERTO LOPEZ, M.D.
1501 Presidential Way, Suite 21
3 West Palm Beach, Florida 33401

4 Re: Jorge Romero vs Berto Lopez, M.D.
Case No.: 2018CA011332XXXXMB

5
Please take notice that on the 10th day of January,
6 2019, you gave your deposition in the above cause.
At that time, you did not waive your signature. The
7 transcript is now available for your review.

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9 9:00 a.m. and 4:00 p.m., Monday through Friday, for
access to a read-only PDF transcript via computer.

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12 www.phippsreporting.com. Once completed, please
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13 all parties.

14 If you do not read and sign the deposition within a
reasonable amount of time, the original, which has
15 already been forwarded to the ordering attorney, may
be filed with the Clerk of the Court.

16
If you wish to waive your signature now, please sign
17 your name in the blank at the bottom of this letter
and return to the address listed below.

18
Very truly yours,
19

20 RICHARD APPLEBAUM, RMR, FPR, CLR
Phipps Reporting, Inc.
21 1555 Forum Place, Suite 200E
West Palm Beach, Florida 33401

22
I do hereby waive my signature.

23

24 _____
BERTO LOPEZ, M.D.

25

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